

PHYSICIAN PRACTICE OPTIONS™

October 15, 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Financial Problems Show PPMCs at a Crossroads

SEC and Others Have Examined Management Company Practices; Wall Street Cools to Once- hot Stocks; Physicians Become More Deliberate

Following four years of exceptional growth, many physician practice management companies are struggling financially because of lack of investor confidence, falling stock prices, new federal regulations, and physician complaints about the way PPMCs do business.

"The PPMC industry is at a crossroads," says Michael Blau, an attorney who is chairman of the Physician Practice Management Company Group of McDermott, Will & Emory, a law firm in Boston. "It is in trouble. Investors have lost confidence and the market is cooling. The better companies, the ones committed to adding value to individual practices by increasing market share and physician incomes, will prosper again, but the industry will never regain the pace it once had."

"It's not an easy business to be in right now," says Paul H. Keckley, vice president of strategic management for PhyCor Inc., a Nashville multispecialty PPMC which last year had revenue of more than \$2 billion. "But it is an industry that is not going to go away."

In July, PhyCor reduced its projected earnings for this year and for next year by more than 10%. As a result, its stock fell 38%, from about \$14 to \$8.73 a share—its lowest point since it hit its high of \$35 in June 1997. PhyCor's announcement caused all PPMC stocks to stumble, according to *The Wall Street Journal*. Since PhyCor is in a leadership position in the industry, when

it reports bad news, investors tend to be unnerved, a Wall Street analyst said.

High Expectations

The industry is struggling today in part because its rapid growth in recent years raised unrealistic expectations among investors about future performance, Keckley says. "Every industry goes through cycles," he explains. "An industry that went from a couple of publicly traded companies to more than 30 in less than three years is bound to go through a period of volatility." The industry grew from about a dozen publicly traded PPMCs at the end of 1994 to twice that number less than two years later. By mid-1998, there were about 45 publicly traded PPMCs, including dental management companies, and about 150 privately owned PPMCs, representing about 40,000 of the nation's 530,000 practicing physicians, according to the AMA.

Early this year, industry experts were predicting that as many as 100 privately owned PPMCs would go public. But those projections were revised after stock prices began to fall and federal regulators began raising questions about the way PPMCs do business (see "SEC Issues Rules on PPMC Revenue Statements," page 9). "There's no way that most of these companies are going to go public now, given current market conditions," Blau says. "The market for initial public offerings in general is cooling, and the IPO market for PPMCs is particularly cold."

(Continued on page 8)

Confusion Expected in the Medicare Program

If you treat Medicare patients, you might expect your patients to be confused by changes in the program. The federal Health Care Financing Administration (HCFA), which runs the federal program for the elderly, has produced the *Medicare Handbook: Balanced Budget Act of 1997*. HCFA has been test marketing the handbook to 5.5 million Medicare beneficiaries in Arizona, Florida, Ohio, Oregon, and Washington state. Initially, HCFA planned to send the handbook to all 38 million Medicare beneficiaries, but it changed this plan after focus groups showed that many elderly enrollees would be utterly confused by the changes in the program and by the explanation of those changes.

The consumer guide is designed to explain to patients their Medicare options, including the original Medicare program, Medicare HMOs, HMOs with a point-of-service (POS) option, preferred-provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, and medical savings accounts (MSAs).

The Physician's Role

In HCFA-sponsored focus groups, beneficiaries who reviewed the handbook were overwhelmed by the choices. As a result of such difficulties, patients may ask physicians to help clear up their confusion about their Medicare options. Many seniors already rely on physicians and their office staff for advice on whether to stay in the original Medicare program, to join an HMO, or to choose another option. For this reason, some patients are likely to ask you to explain to them one-on-one what course of action you think is best for them.

A good source of information for patients is the September issue of *Consumer Reports*, published by Consumers Union, Yonkers, N.Y. Also, physicians can get a copy of the government handbook by calling HCFA at 800/638-6833, or by visiting its Web site at <http://www.hcfa.gov/medicare/mcarpubs.htm>

If you are so inclined, it might help your practice to explain the new options in an article you could write for the local newspaper. Or, you might offer to make presentations to groups of senior citizens. In general, I advise seniors who are chronically ill, who like their physicians, and who can afford Medigap policies (which cover services not covered by the original Medicare program) to stay where they are. Hearty seniors seeking lower premiums may want to enroll in a Medicare HMO, especially if they want prescriptions, eye care, and annual physical benefits. The point is that since you are your patient's best advocate, confusion caused by the government might work to your advantage if you can explain the program clearly and concisely.

A Sad Note

We regret to note the passing of Edward B. Hirshfeld, JD, 48. Hirshfeld was vice president for private sector advocacy at the AMA and a valued member of our editorial Advisory Board. He died suddenly in August. For the past year, Hirshfeld, who was deeply concerned about physicians' legal issues, had contributed to our Health Care Law column. Readers may send condolences to his mother, Barbara Payne, 335 Savage Farm Road, Ithaca, NY 14850 and donations to The Ed Hirshfeld Memorial, Cornell Plantation, One Plantation Road, Ithaca, NY 14850. Donations will be used to create a wildlife preserve and bird-watching station to commemorate Hirshfeld's life-long hobby and passion.



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New Forms of PHOs, MSOs Taking Shape

As a result of significant monetary losses from contracts negotiated between hospitals and physicians over the last five to seven years, many physician-hospital organizations (PHOs) and hospital-owned management service organizations (MSOs) are having financial and legal difficulties today. As a result, many physicians are thinking twice about the benefits of integrating their practices with hospital-based PHO or MSO ventures.

Instead, a second generation of PHOs and MSOs is emerging. The few such organizations that exist are coming under scrutiny by physicians, consultants, and hospital administrators. Among the questions being asked about these second-generation networks is whether they can fulfill the goal of full integration and avoid some of the problems experienced by previous endeavors designed to integrate physician and hospital services.

What Has Gone Before

The first wave of physician-practice purchases by hospitals resulted in claims of mismanagement and financial losses from both parties. Some estimates have placed the losses from some physician and hospital associations at more than \$100,000 per physician per year. Such concerns played a key role in the demise of many hospital-owned networks, says Gerald Benedict, principal at Medimetrix, health care consultants in Cleveland. "Many organizations were created simply as a reaction to market forces and were focused solely on structure and management, as opposed to execution of services. Without that attention to service and care in the forefront, no organization could be expected to succeed," Benedict says. His predictions for the next generation: "Because delivery of services was so frequently lost in the focus, we'll see two things occur. First, existing organizations will be trying to 'reengineer' themselves to concentrate on delivery; and second, those hospitals considering entering the business will have to be less concerned with such matters as who is on the board, and how much reserve equity they've built."

Richard Lilledahl, MD, a consultant with Milliman & Robertson, actuaries and

health care consultants in Seattle, points out that many first-generation organizations were a convenient and attractive option for physicians primarily because physicians are risk-averse regarding capital investments. "We'll see that the next go-round will involve a much higher level of risk-sharing among all participants," Lilledahl says. "This is something that many physicians are not going to be comfortable with since they won't want to take the lead. But it all goes back to incentive structures. New hospital-owned networks are going to need a creative incentive package, which includes some kind of shared risk."

Many Theories, Some Consensus

Much of what is being discussed about the future of hospital-owned practice networks remains theoretical. According to industry analysts, only three groups currently in existence can be termed "second generation" in the sense that they successfully renewed a contract and continue to operate with hospital ownership. Two of these groups are in

to success, he adds. "Hospitals will have to get out of the ownership model and into the support system model," he explains. "This has got to be viewed as a mutually contracted obligation, not an owner-employee situation, which is what seems to have sunk many of the first-round systems."

Jayne Oliva, principal at the Croes Oliva Group, health care consultants in Burlington, Mass., and coauthor of a report, *Physician Partnering: Gaining Value From Physician Practice Management Arrangements* (Governance Institute, LaJolla, Calif., 1997), echoes Benedict's thoughts. "It will be vital to continue emphasizing ways to avoid the trap of building a new management system simply for the sake of creating a system," Oliva says. "You need to build a system only insofar as it is necessary to serve your market or contract. Acquisition and building a management structure are just steps along the continuum to true integration, and many hospital administrators viewed them as the end goal." Benedict agrees, saying, "Integration is a multilevel,

"Many organizations were created simply as a reaction to market forces and were focused solely on structure and management. Without the attention to service and care in the forefront, no organization could be expected to succeed."

—Gerald Benedict, Medimetrix

Northern California; the third is based in Minneapolis. Both geographic areas are mature markets that can support the ongoing evolution of managed care. The analysts did not wish to name the organizations.

"What we've seen in the Northern California system is a real sense of 'enlightenment' in the hospital administration," Benedict says. "If physicians can look to the hospital less as a banker and more as a contract service provider, we may see some success for the second round of hospital-owned networks." The idea of having hospitals purchase physician practices can create barriers

complex process that does not end at structural development."

Both Benedict and Oliva believe that the structure and nature of the relationship between physicians and hospitals need to be reassessed for second-generation hospital-owned PHOs and MSOs to succeed. "Keeping the focus on the relationship is important, but we need to help both parties understand that structure is in service to care," comments Oliva. "In addition to that shift, I suspect we'll be seeing another change in future organizations, and that is toward locality of service."

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“In less mature markets, PPMCs will continue to provide an attractive alternative practice arrangement. That will make it harder for hospital-based PHOs and MSOs to compete.”

—Richard Liliedahl, MD, Milliman & Robertson

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Nathan Kaufman, president of The Kaufman Group, a division of Superior Consultant Co., in San Diego, agrees that identifying a local market and focusing on providing service to that area is going to be important for second-generation organizations. “Much like General Motors, which does not build all its car parts, but instead purchases parts from different contractors, physicians and hospitals should be concentrating on offering a specific product, for a specific market, at a specific price,” Kaufman says. “Physicians need to think about creating niches for themselves, and then marketing those niches as interdependent contractors.” Kaufman cautions, however, that what works for GM does not necessarily work for another company. “You can’t just create a single template for every market,” he says. “So, I don’t see the pervasive notion of a ‘one-stop shop’ emerging as a viable system for a mature market.”

Oliva disagrees and contends that, in fact, many second-generation PHOs and MSOs will embrace the “one-stop-shopping” model as a natural outgrowth of total integration. “The fully integrated system is out there and it will work in certain markets, but only in certain markets,” Oliva says.

Milliman & Robertson’s Liliedahl agrees that providing services locally to patients in a specific geographic area is a necessity for the emerging physician-hospital organizations. “By taking a look at where current organizations are succeeding, you do get a sense that the future is going to be geographically limited,” Liliedahl says. “In a select handful of mature markets, physicians’ awareness of business ramifications is high, and that’s where risk-sharing with hospitals will continue. In some markets, networks are facing high penetration by HMOs and physician practice management companies, which means that both physicians and hospitals will have to think along very different lines. As long as HMOs and

PPMCs remain more attractive alternatives, physicians will continue to forge alliances with them and avoid the potentially more restrictive arrangement of employer-employee offered by hospitals.”

The Role of PPMCs

Given the financial and legal problems that some hospital-based PHOs and MSOs recently have experienced, physicians interested in practice alternatives may be considering a PPMC. Experts disagree as to what the future holds for PPMCs, how they compare with second-generation hospital-based physician networks, and whether they truly are a better alternative for physicians, especially given the recent turmoil among these practice management companies.

Benedict recommends that physicians maintain an open mind about all practice options, whether PPMCs or physician-hospital organizations are involved. If a hospital is building a network, he says, “look carefully at the way the newly structured hospital network is operating. Don’t just rule it out automatically based on the ones that have gone before. If an ‘enlightened’ hospital is at the head of the deal, it will show. They’re the ones that understand the need to help the physicians share in the revenue stream.”

Oliva comments that the best strategies of all organizations may be adopted by others. “As hospital-owned physician networks either restructure or rebuild after an initial failure, we’ll see them adopt some of the things that some PPMCs do well, such as managing the delivery of care,” she says.

Liliedahl maintains that, “it’s going to come back to marketplace, and market maturity. In less mature markets, PPMCs will continue to provide an attractive alternative practice arrangement. Naturally, that’s going to make it harder for hospital-based PHOs and MSOs to compete.”

Some Possible Models

What will the second-generation organizations need to do to succeed? The answer to

this question is, to a great extent, a matter of speculation. A few working, successful models bear watching, however. Terry Fox Stoller, a colleague of Benedict’s at Medimetrix, says several Medimetrix clients in the mid-Atlantic region are examples, but he did not wish to reveal client names. “We’ve seen one organization grow from a medium-sized hospital that acquired two practices into a system that covers 6,000 lives, has a retail product, and does Medicare-risk contracting,” Fox Stoller says. “It is not losing money because it has had significant physician buy-in and a healthy sense of shared risk among the practices.”

Trends to Watch

Predicting what will happen with second-generation organizations is, at best, risky because so few are operating.

Admits Oliva, “I suspect that within the next 10 years, we’re going to see a unique collaboration between hospitals and physicians. For those physicians re-signing old deals, there’s a lot at stake and it’s going to be interesting to see who takes advantage of that and who throws in the towel.”

Says Benedict, “It’s mold-breaking time. The academic centers, researchers, and clinics are the ones most entrenched, and as a result, they will have the toughest road. There will be creative strategies, and the new organizations probably won’t look at all like what we have now, which is good.”

Kaufman predicts that providers will succeed based not on what types of organizations they have built, but rather on how well they provide care. “In turn, hospitals will have to be attractive to physicians by being the biggest and best providers of contracted services they can be,” he says. “But unless these organizations move into offering a specific product for a specific customer, tailored to a unique market, there will be no second generation.”

—Reported and written by Maria Hecht, in Boston.

Physician Group Succeeds After Three Generations of Organizational Change

By Mulloy Hansen, MD

Next to patient care, forming an alliance with provider organizations is of greatest concern to physicians nationwide. Typically, physicians align themselves with hospitals. And while this fit may seem natural because physicians and hospitals have long needed each other as business partners, both sides have complained of problems when physicians have been employed by hospitals. Hospitals complained that physicians' productivity declines; physicians complained that they have lost their autonomy.

Jayne Oliva, a principal in the Croes Oliva Group, physician consultants in Burlington, Mass., predicted earlier this year that there would be "improvements in the next generation of deals between physicians and hospitals." The evolution of Cascade Health Alliance (CHA), in Bellevue, Wash., bears out her prediction.

Lessons Learned

CHA is the result of three generations of struggles to form alliances among physicians and between physicians and hospitals. After overcoming many obstacles and setbacks, including "starting over" twice, we have created what we believe to be the ideal physician alliance. We have lived through what some observers have described as the "element of experimentation" inherent in the first generation of partnerships between hospitals and physicians. As we—and physicians in situations similar to ours—have found, there is little information available about how to do it well.

We learned that what works in forming physician-hospital alliances is a fundamental principle of American business: Concentrate on what you do best and con-

tract out for the services you don't do so well. To our surprise, what doesn't work is a health care delivery system with centralized management. Above all, preserving the individual physician's role in determining what is best for a patient at any given time is crucial. We hope that other physicians can learn from the mistakes we made along the way toward CHA's final evolution, and so have a smoother path than ours was. We hope that our organization's success can provide encouragement to others seeking to start similar ventures.

CHA's origin, development, and growth have mirrored developments within the health care industry. Specifically, the group's evolution reflects physicians' increasing ability to take charge of their economic future. CHA was started as a hospital-physician organization (HPO), restarted as a

The HPO

The first physician alliance in Bellevue was established in the early 1980s in response to problems of market share at Overlake Hospital. The hospital's administration and the executive committee of the medical staff had begun exploring ways to partner with physicians as a means of recapturing lagging market share. Because a large segment of Bellevue's suburban east-side community was seeking medical care in downtown Seattle, the hospital and medical staff decided to cooperate based on their belief that some of that business could be kept at home on the east side. Forming a partnership, they reasoned, could raise awareness in the community that Overlake provided quality care and had resources equal to those in other markets.

The fledgling partnership was named

We learned that what works in forming physician-hospital alliances is a fundamental principle of business: Concentrate on what you do best and contract out for the services you don't do so well.

physician-hospital organization (PHO), and ultimately reborn in its third generation as a physician organization (PO). Currently, CHA's membership consists of a one-to-one ratio of primary care physicians (PCPs) to specialists. As a contracting entity, CHA has 180 physicians providing services to more than 30,000 covered lives. CHA contracts on a capitation basis only and assumes the risk for the physician and hospital components of the health care dollar.

Overlake Preferred Provider Organization (OPPO), which was called an HPO because it relied totally on funding by the hospital. Administrators and medical staff representatives chose that structure based on a visit to Hillcrest Hospital in suburban Cleveland, where they had seen the HPO model in use. In effect, Overlake Hospital was the owner and manager of the HPO and the participating physicians were considered "members."

Mulloy Hansen, MD, has been a practicing physician in family medicine since 1977. In the late 1970s, Hansen led the effort at Overlake Hospital in Bellevue, Wash., to establish a Department of Family Practice. He contributed to the formation of Cascade Health Alliance (CHA), a physician organization in a suburban area east of Seattle. Since 1994, he has consulted with Milliman & Robertson, actuaries in Seattle, and is the author of Healthcare Management Guidelines Volume 5, Ambulatory, Primary and Pharmaceutical Care (published by Milliman & Robertson, 1997).

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Cascade Health Alliance is the result of struggles to form alliances among physicians and between physicians and hospitals. Despite many obstacles and setbacks, the members believe they have created the ideal physician alliance.

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From the outset, however, the physicians gave little support to the HPO. Perceiving no need for the organization, they contracted individually with insurers, which had not yet begun to deeply discount physician services. In the early 1980s, diagnosis-related groups (DRGs) were just being introduced, and managed care did not have a significant presence in many markets. Since physicians were complacent and fairly comfortable, they had little financial incentive to belong to the HPO. Another problem the HPO faced was the perception—and in truth, the reality—that the organization was created to benefit the hospital. As a result, the HPO gradually was dissolved.

From HPO to PHO

The next major shift in health care that affected the Overlake HPO occurred in the late 1980s. At the time, King County Medical Blue Shield, the major insurer in the Seattle area, established a PPO and left some physicians out. The PPO included a provision for a large discount, which was initially of little concern to most physicians in the community. Some physicians, however, foresaw the long-term negative effect such a drop in revenue would have on most practices. When other insurers adopted a similar discounting approach, individual physicians signed deeply discounted contracts in the fear of being left out of a program that might capture a large market share.

It was in this environment that the physician-hospital relationship became appealing to a larger number of physicians in Bellevue. A new entity, Coordinated Medical Care (CMC), was built on what had been the foundation of Overlake PPO. In the developmental stages of CMC, the physician leadership and the hospital administration were careful to structure the board of CMC so that physician representation was predominant.

Unfortunately, physicians in the community were not yet ready to invest the needed capital. So, the hospital provided the

funding, largely to ensure that its own employees would benefit from CMC's ability to contract for medical services.

Because physicians were so much more involved in developing CMC than they had been when the HPO was started, the new organization became known as a PHO. Marketing, operations, and contracting were all handled by the hospital. The physicians developed policy, supervised credentialing and medical management, and structured the reimbursement plan. Also, there was a strong commitment from the specialists on the need for partnering with the PCPs.

The PHO's first contracts were with the City of Bellevue and Overlake Hospital. Each organization had two plans—an indemnity option and the PHO's plan—which allowed the purchasers to compare the benefits of each. The PHO plan quickly proved to be better. The medical costs under CMC were about 30% less than they were under the indemnity plan and CMC shared the savings with the purchasers. CMC also developed guidelines for managing high-volume, high-dollar diagnoses and it performed a health-risk assessment on new members. Once high-risk individuals were identified, CMC could intervene to modify the risks involved.

At the end of the 1980s, physicians were feeling increasing pressure to reduce costs. In 1992, Washington State passed an initiative mandating development of managed care organizations. In response, CMC began accepting a limited number of capitated contracts to test the medical staff's strength to function under, and resolve to succeed under, this new form of reimbursement.

Hospital Competition

The PHO's physician leaders believed that to broaden CMC's appeal to employers, the organization had to be able to provide care for the entire east-side community. Thus, a partnership arrangement had to be struck with Evergreen Hospital Medical Center, the other, competing hospital in the area. Achieving that goal was difficult and even-

tually failed because the physicians participating in CMC distrusted the motives of the administrations of both hospitals. Another factor affecting the medical community was the threat posed by the state's managed care mandate to small physician practices. Most PCPs on the east side practiced in groups of four or fewer—numbers deemed by managed care plans to be too small to be worth accepting the risk of capitation.

At this time, a small group of CMC physicians who practiced predominantly in primary care began meeting to discuss the formation of a virtual group or what's called a clinic without walls. They envisioned a group that would contract with insurers independently of the hospitals and enable the small groups in the community to continue practicing without physically joining together to form large clinics. As this idea grew, it became obvious that the "super-group," as it was initially called, and CMC, the PHO, could not coexist. As a group, the PCPs withdrew from CMC and the organization quickly died.

From PHO to PO

It was time for the physicians to put money behind an organization of their own. The PCPs believed that there should be a one-to-one ratio of PCPs to specialists, but the Bellevue community—and the PHO—had a one-to-two ratio. The first step in establishing a new organization, a PO, was to identify the specialists in the community who were the most efficient and invite them to join. Sometimes, this meant that an entire specialty group would be asked to participate in the PO; in other cases, only one or two physicians were selected. All of the PO's members then were asked to put up capital to start the organization, and about 180 physicians invested \$6,000 each and paid monthly dues of \$125 each to cover operating expenses.

By the end of 1995, CHA was born. Governed by a board dominated by PCPs, the organization views the hospital as a cost center rather than as a partner. While the hospital has a vital role in the delivery of

To start the organization, about 180 physicians invested \$6,000 each.

health care, its goals often conflict with those of physicians, and the physicians believed this conflict could not be resolved if they were operating within the same organization. With a contracting situation, however, each group can set its own goals and freely express its desires. At times, compromise may be necessary for the physicians and the hospital to reach agreement. For example, the physicians who are at risk for the financial cost of delivering care under capitation may believe that certain procedures can be delivered more cost effectively in an ambulatory surgery center than they can in the hospital. Because it is independent, the group can make that decision based on what it perceives is right for the physicians and their patients rather than considering only what is good for the hospital.

In addition to these changes, CHA made an important change in its business operations. The PO established a holding company, in which the physician members have stock, to manage the business aspects of the operation. As a contracting entity, the holding company enables the small-group physicians in the community to continue participating in a full range of insurance plans. The arrangement also makes it more difficult for deep discounters to "divide and conquer" the individual physicians.

CHA offers physicians in solo and in small-group practices—who are increasingly vulnerable to financial problems brought on by reduced reimbursement levels under managed care—a structured environment through which the risk inherent in capitation can be spread over a large group. In the Bellevue medical community, prior to CHA, it was not possible for solo physicians or small groups to participate in such arrangements because they were too small to accept the financial risk of capitation.

The medical aspects of the PO are administered through a committee structure. CHA oversees the medical management and the physician roster. Separate committees handle the distribution of capitation fees, supervision of utilization and practice guidelines, and negotiation of contracts with medical suppliers and malpractice insurers for discounted group rates. A practicing physician in the community serves as the group's part-time medical director. To increase efficiency, reduce inappropriate variation in practice, and improve quality, the physicians use the ambulatory guidelines from Milliman & Robertson, actuaries and consultants in Seattle specifically, *Healthcare Management Guidelines, Volume 5, Ambulatory, Primary and Pharmaceutical Care*. In fact, many of CHA's physicians reviewed the guidelines prior to publication.

Conclusion

As the product of trial and error, CHA derives its strength from a solid understanding, gained over time, of what works and what doesn't work for physicians delivering care. The key for physicians is to focus on their strengths and be willing to contract out for services that others are better equipped to provide. But no matter who is providing care, the physician must be the one to determine what is best for a patient at any given time.

—Additional reporting and writing was done by Jan Odell, in Santa Rosa, Calif.

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“Wall Street generally understands that these PPMCs are attempting to reinvent themselves. And physicians will continue to need capital and expertise to grow their practices.”

— *W.L. Douglas Townsend Jr., Townsend Frew & Co.*

(Continued from page 1)

Investors are nervous because many PPMCs are in trouble financially and are carrying significant debt, Blau says. FPA Medical Management Inc., a primary care PPMC in San Diego, had revenue of more than \$1 billion in 1997, and its stock was selling for \$40 a share in October 1997. In July, however, the company declared bankruptcy, and its stock had fallen to 25 cents a share.

“It’s difficult to imagine how a company grossing over \$1 billion a year ago could be bankrupt today,” says Bill Freeman, vice president of MD Alliance Corp., a privately held PPMC in Atlanta. “One answer may be overacquisition. It bought too many practices to increase its revenue and then found it couldn’t successfully manage the contracts. That kind of situation ruins investor confidence.” MD Alliance has no plans to go public soon, he says, adding, “market acceptance and investor confidence are paramount to any successful IPO, and clearly now is not the time.”

The turmoil in the market is prompting physicians to be more deliberate in deciding whether to affiliate with PPMCs, says Keckley, a member of the editorial Advisory Board of *Physician Practice Options*. “Our negotiations with the physicians, IPAs, and hospitals we’re planning to affiliate with remain strong, the numbers are staying about the same. But generally for the PPMC market, there’s more skepticism and middlemen consultants are being hired, which is slowing things down a bit. Doctors are well-advised to slow down in making these decisions, given the overall PPMC market’s volatility.”

Lack of investor confidence threatens the future growth of privately held and publicly owned PPMCs because a lack of capital makes it difficult for PPMCs to purchase practices. “Many of these private PPMCs are undercapitalized,” says Nathan Kaufman, senior vice president of The

Kaufman Group, a division of Superior Consultant Co., health care management and information systems consultants in San Diego. “That leads them to want to go public to gain investor capital, but going public means competing with big, well-financed PPMCs, and to do that successfully requires a track record. And it takes capital to establish a track record.”

The picture for PPMCs isn’t entirely dismal, however. Kaufman and others say the need for good management will always exist in health care. “Most doctors just aren’t good businessmen,” Kaufman explains. “There will always be a need for someone with management skills to help them gain market share, control costs, and negotiate contracts.”

Delivering Value

“The PPMC market is undergoing some adjustments,” says W.L. Douglas Townsend Jr., managing director and CEO of Townsend Frew & Co., investment bankers in Durham, N.C., that specialize in health care. “Some companies are naturally going to have to prove to the market that they can

We add value by serving the physicians. That’s how we see our role.” FemPartners, a privately owned PPMC in Houston that specializes in serving ob-gyn physicians, is affiliated with about 100 doctors.

MD Alliance describes its operations as basically a merger of physicians and physician groups that share the same goals and agree on the means to achieve them, says Freeman. The result is a physician-centric, cooperative organization whose goals include greater access to capital, growth for each local group, bargaining power with payers, supplemental income to physicians, and a pooling of intellectual capital and management resources, he adds. MD Alliance is affiliated with about 80 physicians.

Physician Unrest

A positive relationship between PPMC management and physicians isn’t always easy. One ongoing problem for many PPMCs is that it is difficult to serve both physicians and investors successfully, say some experts. “Publicly held PPMCs have two conflicting sets of interests,” says Albert

“PPMCs have two conflicting sets of interests. They need to answer to their Wall Street investors and to the physicians whose practices they purchase.”

— *Albert Barnett, MD*

offer value to the clinics they purchase. When the current market shakes out, the PPMCs that have been able to successfully increase market share for their clinics will be the ones that regain value on Wall Street.”

Many observers agree with Townsend, saying one key to success for a PPMC is a good relationship between physicians and management. Danguole Spakevicius, the president of FemPartners, says, “Our physicians are involved in all our decisions, and have complete authority in all clinical decisions.

Barnett, MD, a health care consultant and chairman of the Institute for Health Care Advancement, a research and educational organization in Whittier, Calif. “They need to answer to their Wall Street investors, which means increasing corporate revenue through costly acquisitions. They also must answer to the physicians, who may resent handing over part of their income to finance those acquisitions while seeing little increased value for their own practice. Whether publicly traded PPMCs will con-

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SEC Issues Rules on PPMC Revenue Statements

The ability of a physician practice management company to add value to physician practices depends on the PPMC's ability to raise capital, say health care experts. For publicly traded PPMCs, the capacity to raise capital from third-party investors, such as shareholders, is related to the amount of revenue a PPMC declares in its quarterly and annual statements to the Securities and Exchange Commission: The greater the income, the greater the confidence. Revenue is defined by the SEC as a corporation's net sales plus any other revenue associated with the main operations of the business (or revenue labeled "operating revenue") as indicated on the annual forms known as 10-Ks or quarterly forms known as 10-Qs. For the SEC, revenue does not include dividends, interest income, or nonoperating income.

In 1997, the SEC formed a task force that examined how PPMCs report revenue and whether PPMCs could declare the net income of associated clinics as corporate net income. The SEC considered whether PPMCs should instead be required to limit revenue only to income that comes directly to the management company, that is the 15% to 20% fees PPMCs collect after a clinic's physicians are paid their salaries.

On April 7, 1998, the SEC's Division of Corporation Finance issued a rule clarification regarding the declaration of PPMC revenue. The SEC said: "The changing structure of the health services market and the diversity in arrangements between physicians and the providers of management and administrative services (PPMCs) raise significant accounting and disclosure issues....Disclosure in the PPMC's offering documents and ongoing reports must clearly and accurately describe its business and contractual relationships."

The rule clarification is important because it can limit the amount of rev-

enue a PPMC declares as its own, and that can weaken its profile on Wall Street, says Albert Barnett, MD, a health care consultant and chairman of the Institute for Health Care Advancement, a research and educational organization in Whittier, Calif. "The weaker a company appears to investors, the less capital it can raise, and the weaker its ability to provide long-term capital resources to its affiliated clinics," says Barnett. "The issues raised by the SEC affect physicians, who should carefully examine a PPMC partner's financial stability and how it determines its annual revenue. The questions the SEC asks should be asked by physicians to determine a PPMC's viability as a management partner."

The SEC raises questions that can serve physicians as a template for the development of a contract that adds value to a medical practice, and physicians should not partner with PPMCs that fail to demonstrate financial stability under SEC rules, Barnett says.

The SEC requires PPMCs to include the following information in their 10-K and 10-Q financial statements:

Nature of PPMC's Business and of Its Relationship to the Medical Practices

- Describe the contractual relationship among the PPMC and the medical practices. Discuss who controls the medical practices and how.
- Disclose how the PPMC's fees are determined. If the fees are based on a percentage of certain items, what are those percentages, or what is the range of the percentages? What items affect the calculation?
- Disclose whether the management fee agreements are subject to adjustment, and if so, how adjustments are determined. Are there any limitations on the amount of any adjustments? Can adjustments be retroactive?
- Are there any arrangements between the PPMC and the medical practice groups regarding loans to

the practices or to the physicians affiliated with the practices? If so, what are the terms of these arrangements? Are there limitations on the amount of loans to the practices? What is the priority of payment of loans as compared to management fees by the practice groups?

- Distinguish the services provided by the PPMC from the services provided by the practice groups.

PPMC's Relationship With Care Providers

- Who enters into contracts with managed care companies? The PPMC (or an assignee) or the physician groups? Who is at risk under these contracts? If the PPMC assumes the risk, do any state licensing issues arise? Would the PPMC be subject to regulation as an insurance company?

Is the PPMC Subject to any State or Federal Regulations?

- Describe any state prohibitions on the corporate practice of medicine and discuss their effect on the PPMC.
- Is the PPMC subject to regulation as an insurer?
- What is the effect of federal anti-kickback and self-referral restrictions?

Management's Discussion and Analysis

- Include a discussion of the financial terms of the management contracts. If there are several types of contracts, discuss the financial terms of each type.
- Provide detailed disclosure of the financial terms of individually material agreements.

Other Issues

- File all acquisition agreements.
- File all material management agreements.

More information on SEC rules regarding PPMCs is available at the agency's web site, at <http://www.sec.gov/rules/other/cfcr0498.htm>

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continue to exist and function as they now do is very unclear.”

Most PPMCs purchase a medical group's or a clinic's assets and accounts receivable, and pay the physician owners a set amount in cash and PPMC stock. In exchange, PPMCs are generally paid between 15% and 20% of a practice's income, after expenses, for an extended period, usually 30 to 40 years. Wall Street investors have encouraged these arrangements because they imply financial stability for the PPMC over a long time. Such deals may be beneficial for the group's physicians who are older and approaching retirement. If so, they may receive a big paycheck up-front. In addition to such cash payments, the owner-physicians may realize income over time if the PPMC stock continues to do well on Wall Street.

But such arrangements can be unpopular with a group's younger physicians, who have no ownership interest, do not receive any cash or stock, and see part of their income going to a management company for many years to come.

“We learned through bitter experience that a PPMC deal is good only for the retiring owner-doctors,” says a physician in Reno, Nev., who asked not to be named. The physician is considering leaving the group because he dislikes how the PPMC is managing the practice, he says. “As exit strategies, PPMC arrangements are great,” he explains. “For the physicians who have to live with these deals, they're a disaster.” More than a dozen physicians quit the group this year and went into practice as solo practitioners, he says.

In addition to causing resentment among some younger physicians, PPMC deals may make it difficult to hire new physicians, says Barnett. A group seeking to grow may not be able to recruit the next two or three generations of physicians who would join a practice over the 30 years a PPMC is receiving its 15% cut, Barnett says. “It makes it difficult for these groups to attract new physicians because the physicians don't want to turn over a percentage of their income to a management company,” he explains. “The ability to grow by increasing market share is critical to a group's financial health over the years, and growth requires adding more doctors. So in a sense, these

long-term arrangements can be self-defeating for a PPMC because they can limit the ability to expand market share. And Wall Street is beginning to understand that issue, shown by the decreasing stock value of these companies.”

PhyCor is aware of the problems created among younger physicians and investors when a PPMC pays a large amount of capital to physicians who soon leave a practice, says Keckley. In an effort to strengthen its relationship with the physicians who remain in medical groups it acquires, PhyCor has reduced the amount of capital it pays up-front, which in turn allows it to reduce the amount of money it needs to recover in management fees. As a result, PhyCor has reduced its management fees to 12% to 14% from 15% to 18%, depending on the contract. “If we bring value to practices through cost management and strong managed care contracts, we will benefit down the road,” Keckley says. “Lower up-front payments allow us to more successfully work with physicians to focus on what we should be focusing on: adding value to physician practices by increasing their patient base so they'll be suc-

Human Services issued an advisory opinion that marketing and billing management fees paid to PPMCs based on a percentage of a practice's revenue may violate the federal anti-kickback law. OIG advisory opinions are not legally binding, but some analysts say the opinion could affect the way PPMCs do business. “The opinion is broad in its scope,” says Blau, “but there are steps PPMCs can take to avoid potential problems, such as not requiring referrals to their own networks and charging flat fees for marketing and billing services.”

Also in April, the SEC issued new rules concerning whether PPMCs should be required to limit their revenue statements to income that comes directly to the management company, that is, the 15% to 20% fees most PPMCs collect after a clinic's physicians are paid their salaries, instead of including all of the income earned by the clinics they own or serve as part of their revenue stream.

Regardless of federal regulatory issues and investor concerns, PPMCs can prosper if they work to create financial relationships with the groups they acquire that permit growth and are not inhibiting to new physi-

“The PPMC industry is at a crossroads. It is in trouble. Investors have lost confidence.”

— Michael Blau, McDermott, Will & Emory

cessful now and 10 or 15 years from now.”

Townsend advises physicians to make deals only with PPMCs that enhance the physicians' ability to deliver quality care. “The real question physicians should be asking when they make deals with these companies is whether the PPMC can do something for them they can't do for themselves,” Townsend says. “Initial capitalization, or purchase price, is really an issue only for physicians who want to cash out.”

Regulatory Questions

In addition to investors' concerns and physicians' unrest, PPMCs are dealing with questions from two federal agencies about the way they do business and how they determine net worth in public earnings statements.

In April, the Office of Inspector General for the federal Department of Health and

cians, Townsend says. Some companies are tying their management fees to increased market share, while others are increasing opportunities for new physicians to purchase ownership in their practices. “Wall Street generally understands that these companies are attempting to re-invent themselves,” Townsend says. “And physicians will continue to need capital and expertise to grow their practices. The future of the industry clearly will depend on those companies that bring value to the practices they acquire or manage.”

Strong relationships with the practices it acquires will help PhyCor get through this difficult period, says Keckley. “We are focused on our long-term affiliations with physicians,” he says. “As long as that's how we do business, we'll be in business for decades to come.”

—Reported and written by Martin Sipkoff in Gettysburg, Pa.

Consultant Says Physician Leaders Need to Be Strong and Visionary Entrepreneurs



Thomas M. Gorey, an attorney, is president and chief executive officer of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill. Policy Planning Associates assists physicians in organizational strategy development.

In the coming months, Gorey will be writing a regular column for *Physician Practice Options* on organizational options for physicians. This interview was conducted by Richard L. Reece, editor-in-chief.

Q: Mr. Gorey, for this interview, I would like to focus our discussion on organizational options for doctors. But before we do that, let's begin by discussing your background and how you became an authority on this subject.

A: My background in health care began at the American Medical Association, where I was employed from 1981 to 1992. I started there as a legislative attorney in the Department of State Legislation and then moved into policy and planning-related positions. During my last six years at the AMA, I was staff secretary for the AMA's Council on Long-Range Planning and Development. I worked with the council to assess changes taking place within medicine, health care, and society in general. We looked at some of the trends that would affect physicians and tried to develop organizational strategies for the AMA and for organized medicine to help physicians prepare for the future. In 1992, I left the AMA to form my own consulting firm, Policy Planning Associates, with the idea that I would work primarily for two types of clients: for state and specialty medical societies, assisting them in developing programs and services to meet their members' changing needs, and for individual physicians, helping them to implement successful practice development strategies—particularly in relation to managed care. Although I'm an attorney by training, I haven't practiced law for a number

of years and have focused instead on helping physicians from a business and planning perspective.

Q: Since 1994, you have written several books using case studies to focus on different types of provider organizations. What have you learned from studying these organizations?

A: To answer your question, let's go back to 1993 or 1994, a period of considerable change—and considerable anxiety for physicians. No one knew then what the future would hold in this country for health care and medical practice. There was a real need for information—not theoretical information, there was a lot of that—but practical, hands-on information that physicians could use to help guide them. So, in 1993 we started looking at some of the options that were available to physicians. Our cosponsors for the studies included the AMA, the Michigan State Medical Society, and other state and specialty medical societies that were interested in helping their members understand and take advantage of the changes that were occurring.

“Because there is so much uncertainty in the market, there is a tendency to rush to a particular model as the salvation for all physicians.”

We started by looking at physician-hospital organizations (PHOs) because there was intense interest in them at the time. In fact, they were being held out as the model for the future and were being formed all over the country. During that study, one issue that came up was whether there should be physician organization components in PHOs. Some PHOs had them; some did not. But there was enough interest to spur us to start a separate study to look at the issue. From that study, a separate issue arose: the need for management services, contracting services, and an administrative infrastructure for all of these types of organizations. That issue, in turn, led to a study

of management services organizations (MSOs). Since that study, we've also looked at single-specialty networks, as well as at physician practice mergers, for which we have a study that is soon to be released. Several common themes have emerged throughout the series of studies we have done. Probably the most important and consistent finding is the need for physician leadership. Without strong physician leadership, none of these organizational entities would have gotten off the ground, and none would have been successful.

Q: What do these strong physician leaders have in common?

A: One quality they share is that they are visionary. They're not trapped in the moment. They anticipate the future and plan for it. They are also more entrepreneurial, more business-minded, than many physicians. They enjoy taking on organizational responsibilities. They enjoy being in a leadership role. And they're respected—in both a clinical sense and a business sense—by their colleagues; with-

out that respect, they obviously wouldn't be leaders. Their physician colleagues trust their business instincts and are willing to let them lead. They also have very high levels of energy, which enable them to take on the leadership responsibilities required to get these organizations off the ground at the same time that they maintain a full-time medical practice. Instead of working 50 hours a week, many of them work 80. So, they're able to juggle multiple responsibilities and, to a certain extent, they seem to thrive on the stress and excitement associated with organizational development.

Q: Your writing on single-specialty networks emphasizes physician leadership,
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and you point out that single-specialty leaders are daring risk-takers who often run the specialty networks from their own offices.

A: Right. The single-specialty networks, probably more than any other model we studied, tended to be run by individual physicians. Most of the other models were run by a team of physician leaders. And yes, the single-specialty leaders often did run the specialty network from their offices, using office staff, at least initially. In that sense, the leaders in the specialty network context are even more independent-minded than many of the other physician leaders we dealt with.

Q: Many of these organizations seem to have a definite life cycle. For example, the PHOs blossomed before they faded as the MSO movement began to blossom. Next came the single-specialty network model. Is there a lot of experimentation going on in search of the best model?

A: Yes. And because there is so much uncertainty in the market, there is a tendency to rush to a particular model as the salvation for all physicians. That was particularly true in 1993 and 1994 when health system reform was looming and physicians believed they needed to do something. Also, there's always a certain enchantment with a model that people are not too familiar with. If it appears to be new and in vogue, it tends to attract more attention. We saw that happen with PHOs and to a certain extent with MSOs. So, yes, there seems to be a lot of experimentation going on.

The fact that the popularity of these models ebbs and flows shows that no one model is right for all physicians, but rather it's necessary to evaluate a range of options. Many of those options—such as group practices, independent practice associations (IPAs), and various forms of physician-hospital collaboration—have been around for years. The only thing that's new about some of the options is that large numbers of physicians are attracted to them, possibly because of media attention and the focus on particular models at meetings organized for physicians.

Q: Different models work in different markets. PHOs, for example, have been somewhat summarily dismissed in the literature and yet they have worked well and still work well in rural markets where there's not much managed care penetration. So, would it be a

mistake to be dismissive of certain structures?

A: Yes, it would. Again, it goes back to the tendency to want to identify a particular model as the one that will work for physicians nationwide, and I don't believe that's possible. There have always been markets—perhaps more in rural areas and small communities—where physicians and hospitals have gotten along well and have worked together to pursue common goals and objectives. For these markets, a PHO might still make some sense. But,

“There's always a certain enchantment with a model that people are not too familiar with. If it appears to be new and in vogue, it tends to attract more attention.”

obviously, there are many markets where there are more contentious, antagonistic physician-hospital relationships, which would doom a PHO. That's why, in trying to identify a strategy, the first step in the planning process should be to analyze the market carefully. Perhaps in the past, not enough attention has been paid to market analysis and instead a particular model has been superimposed on physicians regardless of the market dynamics.

Q: In all this experimentation there seems to be a failure of hospital-driven organizations, such as hospital-dominated PHOs and MSOs and hospital acquisitions of physicians. Would you comment on that?

A: For the long term, physicians want to be part of an organization in which they feel a sense of ownership and control. While initially that might have been the promise of PHOs and some other collaborative models, what happened in some cases was there was not enough of a sense of ownership by the physicians. Despite their involvement in getting the organizations started, they didn't have a strong continuing role or a significant financial stake in many cases. So their commitment to the organization may not have been great, and what often transpired was that the hospitals, either intentionally or by default, carried most of the financial and administrative burdens for running those organizations. In hospital acquisitions of physician practices, a similar dynamic was taking place. As soon as the hospital acquired the

practice, the physicians lost that sense of ownership and control—and in many cases, lost a sense of commitment to the future of the medical practice as well. So, whatever approach is taken, to be successful it must entail a strong sense of physician commitment, involvement, and ownership.

Q: Do you think the dynamics are changing; that physicians are becoming truly dedicated leaders in physician-driven organizations?

A: The dynamics are changing. In recent years, there has been a grow-

ing recognition that physicians can't run these organizations on a part-time basis; they need full-time administrators and they need to compensate their physician leaders for the time and energy they devote to these organizations. One shortcoming of many physician organizations is that they aren't always willing to compensate their leaders for those efforts. So, what often happens is that after one or two years, the physicians who were involved at the outset—the ones who had the vision and who put in countless hours to get the organization off the ground—burn out. Unless there are physicians coming up through the ranks who have the desire and the leadership skills to replace them, the organization will falter. One of the downsides in the past was that the physician organizations had no full-time administrators to counter the weight of the hospital administration.

Q: Isn't that partly a cultural problem; in other words, that practicing clinicians basically don't trust physicians who become full-time executives?

A: That's true, but it may be changing. I'm generalizing in saying this, but physicians don't understand the role of management or how administrators add value to the system. The general mistrust and misunderstanding of the role of management are compounded when a physician enters administration. Physicians may ask, “Why would a physician abandon full-time medical practice for administration? And is he or she still a physician we can trust?” But

more physicians are realizing the importance of administrative skills, just as more physicians are getting MBAs and law degrees, and are entering administration on a full- or part-time basis. These physicians understand that without business and administrative skills, they won't be able to go head-to-head with others in the market and they won't be able to lead effective physician organizations if all they have are clinical skills.

As we've studied physician organizations, we've seen a transition from the part-time physician manager, who has no business training but some good instincts and some good organizational skills, to more of an MBA-type physician, who has studied business full time and is looking for either a full- or part-time career in administration. This new role is being recognized as a legitimate career that can be personally and professionally rewarding—not simply as something that has to be done.

Q: *I've always found the Mayo Clinic model intriguing. In it, the physicians run the organizations; the CEO keeps one foot in the clinical camp to maintain credibility and practices a portion of his time each week; and the physicians embrace administrators as part of their team.*

A: "Team" is the right word to use. Successful physician organizations and PHOs appreciate the team approach, in which their organization's governing structure is set up to reflect the team concept and where there is a clear role for administrators and physicians not only for input on the clinical side but on the business side as well. Organizations that have leaned too heavily in one direction or the other, that have been entirely led by an administrator (whether it's a lay administrator or a physician administrator), or that have been led too much by a physician leader strong on the clinical side but not on the business side, have tended to falter.

Q: *Let's now move from the abstract to the concrete. What do you actually do when you consult with physician organizations?*

A: One thing I've learned over the years is that it's relatively easy to form a legal entity; the tough part is planning, analyzing, and determining the best course of action for the group of physicians seeking to form that entity. Our firm assists

physicians and physician organizations in the early stages of their development to assess their needs and goals, to examine the market, and to look to the future before selecting from a variety of models the one that is best for them. That's where we can be of most value; that is, in helping physicians to think through the issues and to address them one by one before deciding on a course of action.

Q: *Is it true that a group of physicians will sometimes undergo a metamorphosis from one type of organization to another?*

A: That is very common, and it is an important point to make to physicians who are embarking down this road. They may initially form an IPA but, after a year or two, as they get to know each other better and feel more comfortable with group decision-making, they may realize the merits of a group practice and become more comfortable with that model. Many of the IPAs and single-specialty networks we looked at have evolved to the point that they realize they need to take on some of the administrative responsibilities for their physician members. They also realize that that is a more

which doesn't have to be terribly sophisticated but that is sophisticated enough to allow them to do some contracting with HMOs. A lot of it, frankly, is not risk-based contracting but rather discounted fee-for-service contracting, although a fair number of them also are involved in capitation. But if they can compile the data they need, which is usually the initial stumbling block, they're in as good a position as anyone else to negotiate managed care contracts once they have a handle on the cost of providing services.

Frankly, physicians should be able to compile that data better than anyone else because, in many cases, the data are being generated and the services are being provided in their offices or by their members. So, assuming they can get the data, there's no reason they can't be effective at contracting. But without the requisite data, they're probably not going to be successful in the managed care contracting arena. So many physician organizations are putting dollars, time, and resources into developing an information system that will allow them to compile data on their practice patterns and costs. It's not only from the perspective of being able to do better contracting but also

"One shortcoming of many physician organizations is that they aren't always willing to compensate their leaders for [their] efforts."

important need for them than some of the pure contracting responsibilities that originally motivated them to organize. Enlightened physician organizations and enlightened leaders of those organizations never fool themselves by thinking that they have settled on the perfect strategy and that all they need to do is put it in place and sit back and coast. They are constantly re-evaluating their situation, and they're willing to be flexible and adapt as the market changes and as their needs change.

Q: *Do you find many integrated groups with enough infrastructure to contract directly with HMOs and to bypass hospitals? Is that going on?*

A: It is definitely going on. Many physician organizations are finding that they can put together an infrastructure,

from the perspective of being able to provide better patient care, which is a serious motivation for many physicians who are forming these organizations. The fact is that they can, through good data, develop guidelines and protocols that will ultimately benefit their patients.

Q: *Is what you're saying then, that with good data, doctors can assume responsibility, risk, and accountability, and that's a good thing if they want to remain in control?*

A: It really is. You can't regain control without being willing to be accountable. Physicians are realizing that fact now, and they're realizing that they have to put systems in place that allow them to be accountable. It's not enough simply to want it; they need to have the administrative and information system infrastructures that will allow them to be accountable. ■

New Regulations Address Medicare Part C

By Katherine A. Nino

The Health Care Financing Administration (HCFA) has released a comprehensive set of regulations implementing the new Part C of the Medicare program, known as the Medicare+Choice (M+C) program. Established under the Balanced Budget Act of 1997, the new program greatly expands the health care options available to Medicare beneficiaries. Under the program, beneficiaries will be able to choose from a variety of private health plans in addition to those currently available under Medicare. The new choices include M+C coordinated care plans offered by HMOs, PPOs, PSOs (provider-sponsored organizations), M+C MSA (medical savings account) plans, and Medicare private fee-for-service plans.

The regulations cover a wide range of subjects, including beneficiary eligibility and enrollment, benefits and beneficiary protections, quality assurance, participating providers, payments to M+C organizations (the entities offering M+C coordinated care

offer these plans. Unlike the current regulations applicable to Medicare managed care plans, the new regulations mandate that M+C organizations adopt reasonable procedures relating to physicians' participation under the plan. Specifically, M+C organizations must communicate to physicians in writing to provide them with any rules that affect the process of direct delivery of services to Medicare beneficiaries, such as terms of payment, utilization review, quality improvement programs, data reporting, and credentialing. M+C organizations also must provide written notice of decisions not to contract with physicians and have in place a process for physicians to appeal such adverse decisions. In addition, M+C organizations must ensure that participating physicians are fully consulted with respect to medical policy, quality, and medical management procedures, including the development and application of practice guidelines.

Recognizing that many managed care organizations delegate both the provision of services and the policy-making responsibil-

ity to appeal such decisions. Before terminating a participation contract without cause, the M+C organization or physician must provide at least 60 days' notice to the other party to the contract.

The Physician-patient Relationship
The new regulations also cover the information flow between physicians and patients. In essence, the regulations protect physicians who share with patients information relevant to various treatment options when such treatments are not covered by the plan offered by the M+C organization.

Physician Incentive Plans
Another key provision in the new regulations targets physician incentive plans used by M+C organizations and by subcontracting providers. This provision, which is largely the same as that previously promulgated under the Medicare-risk program, defines a physician incentive plan as "any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee." The regulations limit the amount of risk for referral services that can be transferred to physicians or physician groups contracting with an M+C organization.

Fee-for-service Plans

In addition to managed care plans, the new M+C program allows M+C organizations to offer fee-for-service plans to Medicare beneficiaries. M+C organizations that offer such plans must adhere to special rules with respect to physicians under contract. Specifically, they must establish uniform payment rates that apply to all contracting physicians, reimburse these physicians on a fee-for-service basis, and make information on payment rates available to the physicians. M+C organizations also must have a procedure for noncontracting physicians to receive instructions before the service is furnished on how to request payment information regarding billing procedures, the amount paid, and the amount a physician may collect from an enrollee. ■

Physicians who wish to be included on the panels of the HMOs, PPOs, and PSOs offered through the M+C program must contract with the M+C organizations that offer these plans.

plans), premiums, appeals and grievances, and contracting rules. Since the scope of the regulations is so vast, this discussion focuses on only one topic: relationships between M+C organizations and physicians. Additional topics will be discussed in future issues of *Physician Practice Options*.

Participation Procedures

Physicians who wish to be included on the panels of the HMOs, PPOs, and PSOs offered through the M+C program must contract with the M+C organizations that

ities to subcontracted networks, HCFA extends the above protections to physicians who are in subcontracted arrangements with physicians who contract directly with the M+C program.

Just as M+C plans must communicate in writing decisions regarding the denial of participation contracts to physicians, a decision to suspend or terminate physician contracts must be accompanied by written notice of the reasons that the M+C organization made such a decision. This notice must include the standards and profiling data used to evaluate the physician, the numbers and mix of physicians the M+C organization needs among its physicians, and an explanation of the physician's right

Katherine A. Nino is a senior attorney, Private-sector Advocacy, for the AMA.

PPMC Partnering Considerations

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

Deciding whether to affiliate with a partner and choosing that partner can be long and arduous processes for a physician group. After making these decisions, the group faces another crucial task: It must work through the final terms and structure of the deal. This process can

be lengthy as well, and it is critical for physicians to engage experienced financial, tax, and legal counsel to ensure that the economic value of the transaction is maximized.

A component of the deal structure that physicians will be especially interested in is

the purchase price consideration. Below is a description of various forms of consideration and the advantages and disadvantages associated with each. In many cases, clinics receive a combination of several types of consideration when they affiliate with a partner.

Form of Consideration	Description / Advantages / Disadvantages
Cash	<ul style="list-style-type: none"> • Highly liquid. • Doesn't allow for tax deferment. • Some potential partners may decrease the total price when physicians ask for a large portion of the purchase price in cash.
Common stock (public company)	<ul style="list-style-type: none"> • Means of aligning incentives of clinic and partner. • Partners usually offer shares that have not been registered with the SEC. Securities law prohibits the sale of these shares for a period of at least one year. • Physicians share in the upside potential and the downside risk of the stock. • Can create ability to defer taxes on the portion of purchase price proceeds received as stock if the transaction qualifies under certain accounting or tax guidelines.
Common stock (private company)	<ul style="list-style-type: none"> • Can be difficult to value the stock since there is no established market valuation. • Value of stock should be based on a significant discount to similar publicly traded companies, offering value appreciation upon a sale or IPO. (Value appreciation may be less likely in the future if the market for PPMC stocks remains weak.) • Future liquidity of the stock is subject to completion of a public offering or sale of stock.
Convertible note	<ul style="list-style-type: none"> • Allows partner to defer payment of purchase price into the future. Interest would be payable to the holder through the date of repayment. • Installment payments usually combined with a convertibility feature that converts the note into a certain number of shares of the partner's stock. The number of shares is usually based on the price of the partner's stock plus a premium (usually 20% to 40%) at the time the transaction closes. • Important to determine whether physicians will be taxed as they receive funds (upon conversion or when the note is repaid) or at the time the note is issued.
Assumption of debt	<ul style="list-style-type: none"> • Typically the partner will assume the clinic's bank debt shown on its balance sheet as part of the affiliation. • While debt assumption does not create cash for physicians, being relieved of debt is the true purchase price. • This portion of the purchase price may be treated similarly to cash consideration for tax purposes.
Contingent consideration	<ul style="list-style-type: none"> • Physicians may negotiate to receive additional consideration if the practice meets certain operational or financial targets in future periods. • Many factors outside the physicians' control can interfere with the clinic's performance, and as a result make this type of provision difficult to value.

Source: Townsend Frew & Co., Durham, N.C., 1998.

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Shifting Focus, PhyMatrix Exits Physician Practice Management Business

PhyMatrix Corp., a medical management company that has managed physicians and physician networks, is shifting its focus to concentrate on clinical trials for pharmaceutical companies. The company has approved a restructuring plan to divest and exit the physician practice management component and its ancillary service businesses, which include diagnostic imaging, infusion, home health, lithotripsy, and radiation therapy.

Instead, the company will link its affiliated hospitals and its 92 physician networks with those of its clinical trials operations in an effort to become the market leader among clinical trials site management organizations. Its clinical trials operations manage drug research sites under contract for pharmaceutical companies. PhyMatrix said this business will grow because pharmaceutical manufacturers are increasingly outsourcing drug trial research. As part of its restructuring, PhyMatrix said it will expand into non-health-care development and continue in medical-related projects.

Headquartered in West Palm Beach, Fla., PhyMatrix Corp. previously had described itself as a physician-driven medical management company that managed physicians and physician networks and operated ancillary health care services in communities nationwide. The company's primary strategy had been to develop and operate provider networks in specific geographic locations through affiliated physicians organized in independent medical group practices, IPAs, or specialty care networks.

Comment: PhyMatrix had revenue of \$346.6 million for the year ended on Jan. 31, but its share price had fallen from a high of \$17 last October to \$5 in August.

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