

# PHYSICIAN PRACTICE OPTIONS™

October 1996

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Doctors Are Regaining Clout Emerging Delivery Systems and Renewed Interest in Direct Contracting Create New Openings

**P**hysicians are beginning to win back some of their former clout. One reason for this shift is that many external tactics to contain physician-generated costs—including utilization review, fee discounts, and practice audits—have failed to control costs. While they may work in the short term, they have not been effective at controlling costs over time.

Another reason is physicians themselves, who generate 80% of health care costs through physician orders, have successfully controlled costs and improved the quality of care in systems in which they have been given control over health care spending. In California, the efficiency and economic performance of large medical groups and independent practice associations (IPAs), such as those operated by the American Medical Group Association (AMGA), Seal Beach, Calif., have helped to cut hospital use among commercial and Medicare populations by 30% to 50%, according to an article in the spring 1996 issue of *Health Affairs* (published by Project Hope, Bethesda, Md.). Written by Alain Enthoven, a professor at Stanford University, and Sara Singer, his assistant, the article says large medical groups and IPAs have consistently outperformed California HMOs in cutting costs and satisfying consumers.

Asking Physicians to Lead  
Finding that physicians—rather than HMOs—may offer the most effective way to control costs, some sophisticated health care buyers are beginning to treat physicians as the solution rather than the cause of their health care cost problems.

In Minneapolis, the Buyers' Health Care Action Group (BHCAG), a coalition of 24 large employers, representing 250,000 beneficiaries and 10% of the Twin Cities market, will bypass HMOs beginning next year and instead contract directly with physicians. "We tried everything else, and we still don't have the right incentives in the market," said Steve Wetzell, BHCAG executive director.

For the past four years, BHCAG employers had contracted with three large health plans, but 70% of all Twin Cities doctors belonged to all three plans. Since the employers have reimbursed workers at the same rate regardless of which health plan they choose, workers had no incentive to choose low-cost health plans.

Beginning next year, the BHCAG employers will contract directly with primary care physicians under a modified fee for service system. If the FFS system succeeds, the employers may move to capitation later, Wetzell says. The winners under this structure clearly are the physicians.

### Physician Satisfaction

Another payer group addressing physicians' needs directly is the Pacific Business Group on Health (PBGH), in San Francisco, an organization of 32 large West Coast employers. Working with the AMGA and the IPA Association of California (IPAAC), in Oakland, PBGH is asking physicians to rate their HMOs on service efficiency and utilization management, participant education, quality of care, and their overall contractual relationship. PBGH recognizes that burdensome HMO rules and regulations make it impossible for many

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## Do We Need a New Specialty: Hospitalist?

As our society ages, the cost of caring for the sick is becoming more nettlesome. Even if we cut hospital utilization drastically, hospitals would remain expensive critical care units, consuming a disproportionate amount of resources. In fact, they should consume more resources than other settings because, despite what critics say, hospitals are the best place to treat the seriously ill. Indeed, the current trend to enroll more Medicare and Medicaid patients into HMOs exacerbates this problem as more of the aged, poor, and disabled flood into hospitals.

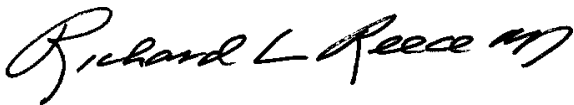
The problem, of course, is that caring for these people efficiently and humanely without busting capitated budgets requires specialized skills. Perhaps the answer lies in fostering a new breed of physician, a "hospitalist," a specialist or generalist dedicated to inpatient care. Such a new breed of specialist is evolving in mature managed care markets, according to an article, "The Emerging Role of 'Hospitalists' in the American Health Care System," in the *New England Journal of Medicine*, Aug. 15. Written by Robert M. Wachter, MD, and Lee Goldman, MD, of the University of California, in San Francisco, the article states that hospitalists generally are members of multispecialty groups and have the responsibility of managing inpatient care. Anecdotal reports from mature capitated markets, such as California and Minnesota, indicate that hospitalists decrease length of stay, hospital costs, and specialty consultations.

Since heavy costs are incurred during intensive hospital stays, hospital administrators in markets with high levels of managed care recognize that an experienced specialist—or hospitalist—can help manage care appropriately while keeping costs down. The best of this new breed knows whom to admit, whom to return to primary care, how to be cost-conscious, how to manage critically ill patients, when to discontinue needless treatment, how to develop effective practice guidelines and protocols, and how to use the DRG system to best advantage to avoid being driven out of business.

But the future of these hospital-based clinicians is not assured for three reasons. First, hospital-dedicated physicians are a threat to independent specialists who derive their income from referrals from other independent practitioners. Second, to prevent "burnout" and to provide backup manpower if needed, every hospitalist should be part of a group, which do not exist in every hospital. Third, hospital-based physicians raise the specter of a European-like system, in which hospital physicians become part of an elite that exclude physicians outside of hospitals.

In the future, the system will be dominated by market-driven medically directed outpatient based groups. If these groups, which are generally not part of the hospital power establishment, can demonstrate lower costs, short stays, better outcomes, better education for physicians, and more satisfied patients, hospitalists will prevail. If hospitalists are perceived to be just another strategem for preserving the status quo, or are hired guns for the hospital, they will fail.

If you are in a multispecialty group or are in the process of forming one, you may want to consider adding a hospitalist or two to your group. It is highly probable that for-profit companies of these hospitalists, sometimes also called "intensivists," will develop to take care of the sick and to pare hospital costs.



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physicians to deliver high quality care cost effectively. To improve quality, PBGH wants to ensure that physicians are not pressured unduly.

### Direct Contracting

These developments demonstrate that purchasers want a system that links all elements of health care, allows for coordination of services, reduces price gouging, and creates rational, accountable leadership. In many instances payers prefer to deal directly with provider groups that assume the financial risk of delivering health care.

Physicians are organizing for direct contracting through various alliances, such as integrated group practices, management service organizations (MSOs), IPAs, and through physician-sponsored or provider-sponsored networks, called PSNs. All of these organizations are market-driven and medically directed. Physicians are in charge, but at risk, and therefore they need the capital, requisite systems, and management and managed care expertise to deal with capitation.

“The provider service network concept is part of a wider movement by physicians to restructure for managed care to improve bargaining leverage for America’s more than 600,000 active medical practitioners,” says Russell Coile Jr., president of the Health Forecasting Group in Santa Clarita, Calif. Writing in the August issue of

*Physician Executive*, Coile says, “Direct contracting has a simple appeal—no intermediaries. Imagine managed care contracts without the costs or hassles or an HMO or third-party intermediary. The PSN is a new form of managed care organization, but without the middleman. Savvy, self-

What Physicians Need  
Physician organizations need skilled professionals, including a seasoned chief executive, a savvy financial officer, a network developer, a marketing expert, and others to execute a strong business plan, to acquire capital, and to grow.

**“Direct contracting has a simple appeal—no intermediaries. Imagine managed care contracts without the costs or hassles or an HMO or third-party intermediary.”**

insured employers, business coalitions, and government health programs are the potential buyers. Doctors and hospitals are organizing provider networks on a regional or statewide basis. Up for grabs are more than 225 million consumers whose health benefits are currently managed by insurance plans, HMOs, and third parties.”

Despite the advantages of PSNs, they still face opposition. The National Association of Insurance Commissioners, an organization in Kansas City, Mo., that represents state insurance regulators, has said PSNs need to have the same capital requirements as other insurers if they are going to accept the financial risk of delivering health care to groups.

On this issue, the lessons of publicly traded physician practice management companies apply to all. In addition to a strong management team, Wall Street investors say the essential ingredients for success of a physician organization are focus on a particular business, such as primary care, single specialty, or disease management. A group practice also should have potential or actual market dominance, represented by market share of 20% or more; infrastructure, including an information system for tracking costs and utilization; a good economic track record; prestige in the community; and strong prospects for expansion, locally, regionally, and nationally. ■

## Direct Contracting: Two Examples

Physicians considering contracting directly with payers might want to consider how the strategy has worked in other markets. Here are two brief examples.

The first one involves Park Nicollet, a large multi-specialty clinic in Minneapolis. Recognizing that businesses in Minnesota were willing to contract directly with medical groups, it developed Park Nicollet Direct, a multi-specialty practice. It collected extensive outcomes data to demonstrate the level of quality that its doctors could deliver and it had an actuarial analysis done to show that costs would be low.

In its marketing efforts, it told employers they could save money by eliminating the middle man. Within 18 months, it had contracted with 20 employers, representing 5,000 covered lives.

The second example comes from Owatonna, Minn., a town of about 20,000 residents south of Minneapolis. In 1992, the five

largest Owatonna employers joined together to seek lower health care costs and improved quality.

In their search for health care providers, the employers met with the Owatonna Clinic, a large group practice, and asked the clinic to form an alliance with the Mayo Clinic in nearby Rochester, Minn., and Allina Health System, a managed care organization in Minneapolis.

Today, each employer contracts with each clinic and each payer sets a per-member-per-month price as a target that is 10% lower than the employers had been paying. In addition, the employers withhold 2% of the premium. If providers hit the price target, they get the 2%; if the providers exceed the target, the employers keep the 2%. The employers also said that specialists could not repeat treatments done by primary care physicians. If they do, the specialist had to pay for the treatment. After one year, costs had declined by 6%. ■

# Debate Rages Over the Role Of Nonprofit Medicine in Managed Care

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

Established in 1812, *The New England Journal of Medicine* represents the heart and central nervous system of the liberal academic medical establishment in the United States. With an enviable track record of publishing landmark research articles, The Journal has the largest number of paid subscribers among physicians of any medical journal, is regularly cited in the consumer media as the bible of medicine, and is closely followed by the investment community seeking information on trends and medical breakthroughs. For physician authors, it is the most difficult medical journal in which to be published in the Western world. It has class, high standards, and impeccable credentials.

Since *The Journal* tends to be liberal and reflect the views of Eastern intellectuals, it should come as no surprise that it frowns on the tactics of the conservative, fast-growing, for-profit managed care industry.

## One critic says there is no place for nonprofit organizations in operating competitive health plans.

The precedent for its anti-managed care stance was set in the early 1980s, when then-Editor-in-Chief Arnold S. Relman, MD, warned of the dangers of the profit-making “medical industrial complex.”

On April 18, *The Journal* started a new phase in this campaign by publishing a “Sounding Board” article by Malik Hasan, MD, often portrayed, along with Rick Scott, CEO of Columbia/HCA, as a champion of for-profit managed care medicine. In his hard-hitting piece, titled “Let’s End The NonProfit Charade,” Hasan, president and CEO of Health Systems International, an HMO in Pueblo, Colo., says there is no place for nonprofit organizations in operating competitive health plans and that such plans ought to be relegated to “the provi-

sion of care for the indigent, medical education, and the development of certain experimental procedures that are not ready to enter the mainstream of medicine.”

### A War of Words

In the same issue was a health policy report, “The Struggle to Reform Medicare,” by John Iglehart, the editor of *Health Affairs*, a health policy quarterly published by Project Hope, in Bethesda, Md. The report questions the future plight of Medicare recipients at the hands of for-profit medicine. The article points out that Medicare HMOs are enrolling 68,000 new elderly each month, and that most of these new enrollees are in states with the highest Medicare payments—more than \$500 per member per month. The struggle to reform Medicare will revolve around encouraging Medicare recipients to enroll in for-profit Medicare-risk plans and in lowering the legal barriers for physicians and hospitals to

form provider-sponsored networks to enroll other Medicare patients.

After publishing a slew of letters from outraged readers, Editor-in-Chief J.P. Kassirer wrote a sharp-edged piece on Aug. 8, “The New Health Care Game,” which was a satire on Hasan’s piece. The theme of the satire was that for-profit HMOs may be a Ponzi scheme that undermines care for the poor, the old, and the disabled and threatens the existence of medical research and education. Kassirer compares running for-profit HMOs to a computer-simulation game and concludes by writing, “It’s easy to tell when you’re winning the game. Each quarter the financial reports will trumpet higher earnings, the price of your publicly traded stock will rise, and your stockholders

will receive handsome dividends. You will be rewarded with stock options, nice fringe benefits, special perquisites, and truly amazing salaries. The game is only a few years old, but already there have been several big winners. If you want to play, you should get into the game soon, but it isn’t clear how long the big profits will last. Oh, yes, I didn’t get the exact name of the game, but it would be easy to find in your local computer store. Just look under ‘entrepreneurship,’ ‘profiteering,’ or ‘exploiting the medical marketplace.’ “

Also in the issue of Aug. 8, *The Journal* published 11 letters critical of Hasan’s point of view. Here are the opening sentences of some of those letters”

- “Dr. Hasan is utopian in his belief about the ability of the market to allocate health care resources well.”
- “Dr. Hasan fails to mention that the market is likely to resolve all outstanding health care issues to the satisfaction of Dr. Hasan but hardly to the satisfaction of the overwhelming majority of the American people.”
- “In Dr. Hasan’s unbridled paean to medical capitalism, his argument is undermined by his failure to appreciate the inherent unfairness of the structure he proposes as regards the health of the poor and the financing of medical education and research.”
- “What bothers me, and I suspect many others, is that the money generated in the for-profit arena is earmarked for the shareholders’ bank accounts, not for the improved access and care of the population served.”
- “Purchasers of health care plans are quite candid in admitting that their individual choices are driven by price, with quality a secondary consideration.”
- “I was taught never to forget the distinction between a consumer (a statistical construct) and a patient (a human being.)”
- “Nowhere in his presentation does Dr.

Hasan address the ethics and moral dimensions of investor-owned HMOs or the way in which a health care system driven by profit will achieve universal health coverage.”

- “As a physician with 42 years with the nation’s largest HMOs, the Kaiser Permanent Medical Care Program, I was

“In *Animal Farm*, George Orwell concluded his allegory with the words, “The creatures outside looked from pig to man, and from man to pig, and to man again; but already it was impossible to say which was which.’ Columbia/HCA insists that medicine is a business, and increasingly imposes its rules on the competitive game. If non-

United HealthCare, U.S. Healthcare, Columbia/HCA, MedPartners, PhyCor, and Salick Cancer Care—are publicly traded. Conversely, the nonprofits— academic medical centers, voluntary community hospitals, and large staff-model HMOs—are struggling to survive.

While managed care is an easy target, its critics are missing an essential point: Health care purchasers have voted overwhelmingly in favor of commercial managed care because costs are lower and more predictable and by demanding improved quality and outcomes, they also get satisfied enrollees. More than 70% of employees at mid-sized and large U.S. corporations are enrolled in managed care plans, and that proportion is likely to grow to 90% by the year 2000.

In the late 1980s and early 1990s, purchasers awakened to the fact that under the traditional fee-for-service system, one part of every premium dollar went to pay for care of the uninsured, another part went to pay for the underinsured, and another part went to pay to train new doctors. With health care costs rising by double-digit rates year after year, purchasers began to look closely at how every premium dollar was spent. Today they pay only for the care their workers receive, no more and no less.

Heavy cost cutting left academic medical centers and society as a whole with two difficult questions: How do we fund care for the uninsured? And who pays to train new doctors and to conduct medical research?

**The criticism of managed care is well placed, but if one follows the growth, momentum, and success that managed care has fostered one finds for-profit medicine. The market has spoken, and it has picked the denizens of the investor world.**

annoyed and amused by Dr. Hasan’s premature attempt to write Kaiser’s obituary.”

To which, Dr. Hasan tartly counters: “Some of the disappointing responses to my Sounding Board article reveal the writers’ phony idealism, confusion, and sophistry.”

#### Criticizing For-profits

In that same Aug. 8 issue, Robert Kuttner, co-editor of *The American Prospect*, published in Cambridge, Mass., criticizes for-profit medicine in an article titled, “Columbia/HCA and the Resurgence of the For Profit Hospital Business.” “In the near future, we will see either a growing convergence in the behavior of nonprofits and for profits or a sharper distinction between institutions with a community purpose and those driven by the bottom line,” Kuttner writes.

“Convergence would intensify the pincher pressure on medicine from managed-care players on the one side and profit-maximizing hospitals on the other. It would probably further squeeze patient care and physician autonomy. It would increase the tension between doctors’ professional and entrepreneurial roles. It would make a self-fulfilling prophecy of Columbia’s often-repeated claim that there is no effective difference between the two sectors and that tax exemptions are a waste of public money.

profits are to retain their claim to fiscal and moral difference, they will need not only to match the chains lawyer for lawyer, ad for ad, market strategy for market strategy, and cost saving for cost saving, but also to be clearer about their mission. And society, through better regulation and disclosure, will need to fashion clear ground rules—cede them to the market.”

The result is that in the pages of *The New England Journal of Medicine*, spokesmen for established medicine have criticized for-profit managed care by saying it has gone too far. Seeking to seize the moral high ground, they have questioned the motives and morality of for-profit health care orga-

**Two questions remain unanswered. How do we fund care for the uninsured? And, who pays to train new doctors and to conduct medical research?**

nizations. Such criticism may be well placed, and certainly managed care has its faults, but if one follows the growth, momentum, and success that managed care has fostered one finds for-profit medicine.

The market has spoken, and it has picked the denizens of the investor world. The fastest growing health care companies—

These are important questions that go unaddressed by managed care’s detractors. Market forces will not let managed care simply wither under criticism. Organized medicine needs to ride the horse in the direction it’s going while also trying to find solutions to the onerous social problems that cost cutting has left behind. ■

# Are Orthopedic Surgeons Prepared For Managed Care?



Bernard A. Rineberg, MD, is a principal in BAR Health Strategies, physician consultants, and is past president of the American Academy of Orthopaedic Surgeons. A member of the editorial board of Physician

Practice Options, Rineberg is an orthopedic surgeon and an expert in health care delivery and integrated delivery systems. He has advised health care provider groups, professional associations, and corporate leaders on health care strategy. In addition, Rineberg works in an orthopedic practice and founded Brunswick Orthopaedic Associates, in New Brunswick, N.J., has served as an administrator of a five-person orthopedic group, and founded the Sports and Orthopaedic Rehabilitation Institute of Central New Jersey. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

**Q:** Dr. Rineberg, as a practicing orthopedic surgeon, what do you see as the options for orthopedic surgeons and for specialists in general?

**A:** First of all they can come together with their hospital as a group. Singly they can come together with their primary care physicians and other physicians in their communities. They can get involved in an orthopedic network, and possibly even get involved in an orthopedic group practice without walls. They can get themselves involved with investor-owned companies.

**Q:** Are you aware of any existing orthopedic networks?

**A:** Yes, several have been formed and even more are in the early stages of formation. Some have been successful, and some are on the brink of being successful. I define success as obtaining exclusive contracts to a significant number of lives.

**Q:** You're the former president of American Academy of Orthopaedic Surgeons, and I understand that the academy is hosting a series of managed care conferences for orthopedic surgeons. How are those going and how are they being received?

**A:** They're building momentum. We've given them now in five places and we'll be giving them in four more locations in the fall. The attendance started off slowly and has increased ever since we've been giving them. The thing that's been most gratifying is the fact that some 94% to 95% of the people who have attended the course have rated it good or excellent.

**Q:** What are they learning that's so useful for them?

**A:** They're learning what managed care is all about. They're learning what their options are in regard to managed care, and they're learning how to take risk, what risk means to them. They're learning how to calculate the worth of their product, including the different operations and office procedures, and learning how to turn those into a capitated arrangement, if necessary, and then make capitated arrangements profitable.

**Q:** One of the models that many observers advocate are large primary care driven groups in which the primary care physician serves as a gatekeeper. Is it correct to say that you don't believe that's necessarily the model that will prevail on the East Coast?

**A:** There has been some activity within some HMOs backing away from that as a model. Those HMOs are finding it better to triage in one manner or another and then go right to the specialist. There are some that advocate the reverse. That is, they say the patient should go first to the specialist and if the patient does not need specialty care, then he or she can come back to a different level of service.

The problem that everyone seems to see is that in many instances a primary care physician is not prepared to do case management and that's what they have to be doing in a managed care environment. There are certain things that they need, such as information on drug interactions, treatment priorities, treatment protocols, outcomes data. Until they're able to get this information and master it, then I don't believe they're going to have the significant say that some think they should have in managed care.

**Q:** You may be right. When I was interviewing the medical director of one of the largest managed care organizations, he said his health plans have had great success with open access models, in which consumers go directly to a specialist. This managed care organization found little difference in cost between the open access model and the gatekeeper model.

**A:** Yes. I understand that one of the HMOs here in New Jersey is considering that model. In all of these things, there's going to be a pendulum effect in that a move toward tighter control of physicians will be followed by a move to looser control. What many observers do not understand is that the level of training in the various specialties is so high that specialization becomes somewhat narrow. While some may call it narrow, it means that the specialist brings to bear a great deal of expertise, and I'm not sure the primary care physician could ever achieve that level of expertise.

**Q:** Changing gears a bit, I understand that Medicare has initiated a program of orthopedic and cardiovascular centers of excellence. Could you tell us about that?

**A:** This program is operating in two districts now, the California District, which includes several states around California, and the Chicago District, which includes several states around Chicago. There is a request for proposals out to all the hospitals in those two areas asking them if they want to apply to become a Medicare Center of Excellence. These Medicare Centers of Excellence will really just take into account certain procedures.

In order to win the federal contracts these hospitals will have to submit a bid for this work, and it is anticipated that the price of their bid will be less than a combination of Medicare Part A and Part B at the present time. The price will include physician services, anesthesiology services, physical therapy, outpatient care, and inpatient services, and it'll be treated as a bundle. The hospital will get the payment and then will divide it up to the various other subcontractors, if you will.

**Q.** *Has this proposal generated a buzz of conversation at orthopedic meetings?*

**A.** Yes, It's become a significant issue for two reasons. Number one is that they are going to call these hospitals Medicare Orthopedic Centers of Excellence when really they're just dealing with total joint replacement in the lower extremity. Calling any hospital a Medicare Orthopedic Center of Excellence will give the public a false impression of what is going on within that institution.

The second issue, which is quite worrisome, is the fact that the hospital will be the major contractor and will be asked to divide up the dollar among the different entities involved in the care of the patient. The hospitals are going to have a hard time paring their costs to meet the demands of these contracts. The result may be considerably diminished orthopedic remuneration.

**Q.** *Do you believe that it is possible for a specialist and physicians in general to work amicably and productively with hospitals over the long run? After all, there are significant issues of control. I know you've been active at the Robert Wood Johnson School of Medicine Hospital in New Brunswick, N.J., and been head of their staff and so forth. How do you look at that scene?*

**"There's a lot of orthopedic surgeons who aren't catching on. They have no idea that they have to understand the new rules in the marketplace in order to start dealing with it. And, it's my opinion that they have to start dealing with it almost yesterday."**

**A.** You're asking a tough question, especially over the short run. Over the short run we don't know which hospitals will survive over the next five years, and if you're involved with a hospital that is not going to survive, you're going to have a whole lot of trouble because there's going to be a problem in obtaining good services as well as in obtaining reimbursement.

Over the long run, when the hospitals consolidate, there'll be a much better chance to work out good deals with hospitals. However, not everyone is going to participate in those deals, and some physicians

will lose their practice base because they will not have a link to the hospital.

**Q.** *If you read some of the projections, such as those produced by the Advisory Board, in Washington, D.C., you see that in five years*

*there'll be 150,000 too many specialists in this country and 40% of orthopedic surgeons will be unnecessary. Does that scenario ring true with you, and does it frighten you?*

**A.** Oh, yes, it frightens me and the scenario very well may ring true. And if it does there's going to be a lot of orthopedic surgeons doing other things that they're not doing today. However, I think it's going to be longer than five years. Although there are certain signs on the horizon now that show we may be oversupplied, such as recent statistics from the AMA that showed that 6% of orthopedic surgeons who finished their programs in 1994 still did not have

full-time jobs. The excess problem will come to bear as we get into more capitated situations and when we start getting more and more volume controls.

**Q.** *Since you're taking an active role in teaching orthopedic surgeons to cope with these problems, is it correct to assume that you believe they can be solved?*

**A.** I think they're solvable, yes. But the interesting thing is that even though the attendance at our courses has been pretty good—in nine courses we've averaged about 130 to 140 orthopedic surgeons, which gives us a little over 1,000 partici-

pants—almost half of the audience has been orthopedic administrators. There's a lot of orthopedic surgeons who aren't catching on. They have no idea that they have to understand the new rules in the marketplace in

**"Calling these hospitals Medicare Orthopedic Centers of Excellence when really they're just dealing with total joint replacement in the lower extremity will give the public a false impression."**

order to start dealing with it. And, it's my opinion that they have to start dealing with it almost yesterday.

The market is moving very quickly, and too many orthopedic surgeons feel that they don't understand it enough to get involved. But they must get involved, because otherwise they're going to be left behind.

**Q.** *It has been said that there are 51 states in the United States and the 51st state is the state of denial. Have you encountered the state of denial on your trips?*

**A.** Oh, very much so. Not only the state of denial but the state of hostility. When we start working with these surgeons in our courses, there is a great deal of hostility in a lot of these audiences, at least initially. After a while, we burn through the hostility, because everyone wants to find a scapegoat and sometimes they look to organized orthopedics as being the scapegoat. But what's drowning the system—the real scapegoat—is industry's need to control health care costs.

**Q.** *Is it correct to say that you believe that managed care has its upside, too? That it makes us aware of what things cost?*

**A.** Not only does it make us aware of what things cost, but for the first time, it forces us to examine our processes. Our processes have developed over the past 100 years, and in that time we have not made significant changes in those processes. As a result, we're still dealing with a cottage industry, a \$1 trillion cottage industry. So, we have to start re-engineering and restructuring how we do things, and there are too many things that we do just for the sake of having done them that way for the past 50 years. ■

# Developing an Integrated Delivery System: The Physician's Role

By Alan Schwartz, MD, MBA



Alan Schwartz, MD, MBA, is director of Clinical Management for Physician Programs, at The College of Managed Care at Friendly Hills HealthCare Foundation, LaHabra, Calif.

Since the early 1990s, integrated delivery systems (IDS) have become increasingly popular. Traditionally, physicians have shied away from participating in such highly structured health care delivery systems. But as health care becomes more competitive, complex, and institutionalized, physicians must consider anew the advantages of an IDS and develop a thorough understanding of the structure, purpose, and intent of these organizations.

One IDS that has successfully educated physicians about the realities of IDS is the Friendly Hills HealthCare Network (FHHN), one of the largest IDSs in the

Their goal was to develop a viable health system to meet the needs of California's health plan sponsors and patients while safeguarding the physician's ability to practice medicine in an optimal environment.

FHHN began accepting full-risk managed care contracts more than 25 years ago. Its initial charter was to serve the Orange County market. As managed care became the dominant delivery system in California, Friendly Hills grew to become one of the largest medical groups in Southern California. In 1989, the organization took the first step toward vertical integration with the purchase of a 274-bed acute care community hospital, La Habra Community Hospital, now known as the Friendly Hills Regional Medical Center (FHRMC). Following this acquisition, FHHN acquired several local independent practice association (IPA-model) physician practices. In 1994, FHHN converted to a nonprofit entity, Friendly Hills HealthCare Foundation. In July 1995 Caremark International, a diversified health care company in

provides dialysis, home health, and tertiary services. It has 4,000 employees, including 400 multi-specialty physicians and allied health professionals, in 47 facilities located throughout Southern California. It serves close to 400,000 patients.

## Making an IDS Operational

Based on FHHN's experience in developing an IDS, the physician managers of the organization have identified five key functions vital to the creation of a successful IDS. These functions include:

- Aligned incentives,
- Compensation and productivity,
- Horizontal integration,
- Clinical practice guidelines and critical pathways, and
- Information systems.

**Aligned Incentives.** Over the past 30 years, hospital administrators and medical staff members have battled each other. Administrators want profitability and efficiency. Medical staff providers want autonomy, respect, and compensation, and individual physicians want control of their professional destinies.

Therefore, FHHN needed to realign the incentives between the hospital and the medical staff. As a first step in this process, FHHN identified the key services needed to deliver a comprehensive, quality-oriented continuum of care, including primary, ambulatory, acute, tertiary, long-term, hospice, and home care. Each of these key areas also could be thought of as a business unit. There was the hospital, for example, the outpatient clinic, and the home care unit, and each of these units must have a business strategy. Under the Friendly Hills model, each specific functional unit, such as the hospital, also has functional strategies for such operations as marketing, human resources, and finance. This strategy gives these key areas autonomy over certain functions while allowing the flexibility that fosters efficiency.

Another factor that helped FHHN align

**Under fee for service, physicians are rewarded based on short-term goals. But in an integrated system, some physicians needed to be reoriented so that they could focus on serving the entire provider organization over the long term rather than focus on their own personal financial goals.**

nation. Based in the Orange County town of LaHabra, Calif., the organization has been developing and expanding its services as an IDS since 1989. FHHN's experiences over the past several years demonstrate that while it is possible to create an IDS, true success requires continual change.

Two factors that undoubtedly have helped FHHN adapt to an IDS are that the organization is familiar with managed care and was founded by practicing physicians.

Northbrook, Ill., bought the foundation's assets, putting Friendly Hills back into an equity model. The foundation remained in place, albeit much smaller and independent, and its mission includes community service, patient and provider education, and research. The network of providers recently expanded across Southern California with the acquisition of 29 medical clinics from Cigna Health Plans. In addition to the hospital and medical group practices, FHHN

all parties' interests was a consolidated balance sheet. In traditional settings, hospitals and physicians provide services to patients separately and are paid separately by patients, insurers, or government programs. Considerably more money comes into the hospital than into other areas of an integrated health care system. When hospitals control this income, administrators may be tempted to funnel more funds into hospital systems at the expense of other components that do not bring in as much money. FHHN believed, however, that if the hospital retained control of the dollars, there would be less incentive to improve the IDS infrastructure. Developing business units under the FHHN management umbrella and using a consolidated balance sheet forces the hospital to be more accountable to other service areas and to view itself as a cost center rather than a revenue center.

**Compensation and Productivity.** With the purchase of the hospital, FHHN acquired a comprehensive array of products, services, and locations to enable it to compete head-to-head with other managed care organizations (MCOs). The organization was quickly awarded full-risk contracts by several health plans.

Under full-risk plans, the provider organization has the sole financial responsibility to provide all health care services to a defined population for a specific period, usually expressed as a per-member, per-month capitated rate. Except for a small administrative fee and withholds or risk-pool funds, which the health plan will take off the top, all capitation funds go to the provider organization. If the plan meets its goals, the health plan redistributes the withholds or risk-pool funds to providers.

Full-risk contracts generally cover what's called the global scope of care, including home health, skilled nursing facilities, ambulance services, acute hospital, and physician services. In addition, full-risk includes the institutional and professional costs of care. Therefore, savings, if any, are not shared with the health plan. Full-risk contracts mean more revenue for the IDS. With this increase in revenue, however, comes the burden of managing capitation income properly and efficiently. FHHN found that when the hospital and medical group were under global capitation, aligned financial incentives could become a reality

because all components of health care delivery could be seen as part of a continuum in the health care process. With this structure completed, a compensation formula could be developed to reward those providers who were part of the in-hospital team and reward each individual as the company became more profitable.

Under fee for service, physicians are rewarded based on short-term goals, such as total services billed. FHHN found that in an integrated system, some physicians needed to be reoriented so that they could focus on serving the entire provider organization

**Physicians may balk at arrangements that blur distinctions between providers but when doctors manage the process, it is easier for them to give control to other professionals.**

over the long term rather than focus on their own personal financial goals. This reorientation included educating FHHN physicians about the need to adopt a new philosophy regarding productivity. With the restructuring of the organization to the foundation model, all physicians were paid a salary. Under this model, many administrators have found that physicians develop a 9-to-5 mentality in part because physicians held no equity in the organization, which may have sapped their enthusiasm and willingness to work beyond 9 to 5. When Caremark bought the company, it converted FHHN back to an equity model and the organization instituted a salary-based plan that included performance incentives. This plan helped to show physicians that what they did affected the organization and their own income.

To keep physicians financially motivated, productivity and patient satisfaction were measured and reported in physician performance evaluations conducted annually by department heads. These evaluations also could be conducted by physician peers. Self evaluations also have been done. These reports were then reviewed by an elected compensation committee that sets each physician's salary. The evaluations can result in a spread of as much as 20% above or below a median salary range for each specialty.

**Horizontal Integration.** For organizations

to be integrated vertically, they must first be integrated horizontally and then the lines of demarcation must be redrawn among health care providers. The goal of this approach is to place the patient, rather than the provider, in the center of the delivery system.

A successful IDS will blur the lines of distinction between providers, empowering other professionals besides physicians to make decisions regarding patient care. In an IDS, for example, pharmacists manage certain portions of patient care. In this instance, the pharmacist would manage the prescribing of prescription drugs such as

anticoagulants Heparin and Warfarin for cardiac patients or those with blood clots or antibiotic dosing in cases of renal insufficiency. Such decisions would be made by pharmacists following guidelines developed by physicians.

When physicians create and manage this process, it is easier for them to give control of certain functions, such as pharmacy, to other professionals. This process is also made easier when all parties know that all vital information will be communicated properly and frequently. When done correctly, the utilization of the full spectrum of health care providers will result in a more consistent approach to treatment of specific diseases, better management of these cases, and significant cost containment from an informed use of a drug formulary.

**Critical Practice Guidelines.** Critical pathways and clinical practice guidelines (CPG) are tools to assist practitioners in delivering integrated patient care. Cholesterol management or dosing and delivery of thrombolytics in acute myocardial infarction would be an example. At FHHN, critical pathways are termed multidisciplinary action plans (MAPS). Implementing CPGs is a challenge for most institutions despite the proven ability of guidelines to improve quality and outcomes. The single greatest barrier to implementation is quite often the physician. It is

not unusual for a physician to view the utilization of critical pathways as diminishing his or her ability to make personal treatment decisions. However, this misperception can be countered when physicians are invited to participate in developing and

track not only encounter data, eligibility data, benefits, billing, and productivity data, but also to include a database of clinical information about patients. The data available need not include routine day-to-day information, such as progress notes,

and notes, test results, patient history, operative notes, and discharge summaries would help streamline care and simplify the process of converting to electronic records.

**Physicians may view critical pathways as diminishing their role in treatment decisions, but this misperception can be countered when physicians are invited to participate in developing and implementing the guidelines.**

implementing guidelines and protocols.

The use of pathways allows a health care organization to use an integrated approach to patient care. Some institutions are using combined nursing, physician, and ancillary services to follow one pathway throughout each patient's stay. Critical pathways are implemented most easily with a small group of admitting physicians, such as an in-house team. Since it will be impossible to cover all diagnoses, successful organizations using pathways will achieve implementation rates of 75% to 85% at best. The FHRMC has more than 40 critical pathways in place. In some areas of the hospital, such as the subacute rehabilitation unit, a 95% usage rate has been reported among those cases for which pathways exist. The incorporation of a policy with regard to guidelines and pathways does not mean that physicians must follow what's called cookbook medicine in all instances. Those patients with multiple and complex medical or surgical problems will represent a variance and should be followed in a more traditional manner, such as with case management.

**Information Systems.** At some point in the not too distant future, IDSs will be able to provide a completely electronic medical record to all providers of care at all sites of physician-patient interaction, including the bedside. Using electronic medical records exclusively will require a major philosophical and financial commitment by both the physician and administration. It also will require extensive education to ensure that data are entered accurately.

Medical information systems need to support an integrated system by being able to

Rather it should contain information such as an accurate problem list, current medication list, allergies, immunizations, and family history. Making such records available at many points in the delivery of care would eliminate the continuous querying of patients with the same questions by three to four providers of care upon admission to the hospital. When stored in a relational database such information as consultation dates

### Conclusion

Moving toward an IDS involves not only re-engineering of current systems for inpatient and outpatient care, but also retraining and cross training physicians, nursing personnel, ancillary personnel, and anyone involved in delivering patient care. While many of the rest of the players vital to the delivery of health care stand ready to rethink their roles, physicians traditionally have been hesitant to change. Many physicians' views have been ingrained since residency, and naturally may be difficult to alter. By becoming more involved in local quality improvement projects, necessary system changes will become apparent. It is important to remember that the challenge to physicians is in not only the process but also the implementation. At Friendly Hills, the experience of creating a successful IDS has taught physicians the importance of individual and organizational flexibility.

## Defining an Integrated Delivery System

Miller & Holguin, health care consultants in Los Angeles, define an integrated delivery system as a strategic alliance between hospitals and physicians. The two entities share risk through common ownership, governance, capitalization, revenue, planning, and management in a variety of organizational models. An IDS may be owned by medical groups, hospitals, physician-hospital organizations, (PHOs) or MCOs.

Many factors have contributed to the rise of this type of system, including the desire among health care purchasers to reduce costs, the trend away from inpatient and toward outpatient care, and the emerging dominance of capitation. Well suited to an IDS, capitation fosters efficiency in providing care, a cornerstone of such delivery systems.

The goal of the successful IDS is to achieve better quality health care for

patients and lower costs for payers. Miller & Holguin say these goals are accomplished in a variety of ways, including:

- Implementing managed care principles, such as integrating all health care services, from primary care physicians to specialists and from hospital care to ancillary services, such as home health.
- Creating uniform administrative practices.
- Developing clinical practice guidelines to provide protocols for the most effective and efficient provision of care and a solid legal base for care decisions.

To be successful an IDS must have access to a large number of patients, primary care physicians (PCPs), and specialists; the capital needed to assume risk; and the management skill necessary to run a large corporation. ■

# How Physician Companies Succeed

By Brooks G. O'Neil



*Brooks G. O'Neil is a managing director and a research analyst specializing in health care for Piper Jaffray Inc., an investment banking and securities brokerage firm in Minneapolis. He is also*

*a member of the editorial board of Physician Practice Options. The second of two parts, this article is adapted from a presentation O'Neil made at the Physician's Capitalization Conference in Boston. Part one, "Success Factors for Physician Companies," was published in September.*

**T**here are several specific examples of successful public companies that we believe physicians should focus on intently. These operations are models of the best run physician practice management (PPM) companies.

The first company to focus on is PhyCor Inc., in Nashville, Tenn., one of the nation's largest practice management companies. The PhyCor companies manage multi-specialty clinics and IPAs with 7,000 physicians in 41 states. It is the most successful public company in this group because it has superior management, a very focused and replicable model, a history of operating performance, and geographic concentration.

Now someone might ask: How can you say PhyCor has geographic concentration when it operates in more than three dozen different markets? By acquiring an established multi-specialty group in a secondary market, PhyCor easily achieves local market dominance. It is building managed care expertise; it has an effective physician mix that I think is economically viable. It has a well established growth strategy, and its returns at the unit level are good and improving.

PhyCor is an example that all PPM company managers should review very closely. PhyCor has done a great job in the public market, and we believe that it will

continue to enjoy tremendous success as we go forward.

## Other Examples

In addition to PhyCor, there are a number of single-specialty companies that are great models as well. One is Physician Reliance Network, in Dallas, which focuses on the oncology business. Physician Reliance Network has been in the oncology business since the late 1970s in one form or another. It is lead by Merrick Reese, MD, a practicing oncologist and a very successful business person. He's built a strong team. The company has focused intently for more than 10 years on building local market dominance in Texas. It has only recently begun to put toe holds into new markets, which it will do cautiously. It has been generating significant profitability in Texas and it can use the same practice model in all 50 states over the next 10 or 20 years. There's an enormous opportunity in oncology.

A second example is MedCath Inc., based in Charlotte, N.C. The focus of its business

the reasons for the success of MedCath are the following: It has a highly focused model, and it has demonstrated strong performance. It has a strong management team, and it can replicate that model in many markets nationwide. In addition, it is highly profitable.

Just as cardiology is an area that is ripe for growth, there are many other such specialties, such as eye care, orthopedics, women's health, and infectious diseases, that we believe offer significant opportunity. In primary care, however, there is not a good model in the public market today.

One company that has used primary care physicians (PCPs) successfully, however, is OccuSystems, in Dallas. Founded by a physician, Richard Rehm, MD, OccuSystems focuses on the occupational medicine business. The company is the largest consolidator of PCPs who focus on occupational medicine. As many physicians know, workers' comp is a \$60 billion business in this country, yet until recently there was limited managed care penetration in this market.

**Just as cardiology is an area ripe for growth, there are many other specialties, such as eye care, orthopedics, women's health, and infectious diseases, that offer significant opportunity.**

is one that is truly exciting, the management of people with heart disease. In the United States, we spend over \$100 billion per year on heart disease, and MedCath is the only publicly traded provider organization focused on that disease.

When we first started looking at the stock, MedCath had a price-to-earnings (PE) ratio of about 12 or 13 because most people thought it was a hospital company. Today it has a PE of 30, which makes MedCath's cost of capital very attractive as the company considers expanding. Among

OccuSystems has a superior model and strong management. In the past, it has been tremendously successful in the public market, and it's going to grow at a rate of 30% to 50% annually for as far out as I can see.

**Hospital-based Services**  
Other examples of companies that will be successful are those built on what has been traditionally hospital-based disciplines. Many physicians may have a hospital orientation or come from hospital-based disciplines, such as emergency medicine, anes-

thesiology, radiology, neonatology, and others. When I first started looking at this business, most people thought hospital-based physicians were uninteresting. The PE

opportunities abound. Also, there are tremendous opportunities in selected niche markets, such as Medicare and Medicaid, particularly as managed care rapidly trans-

we will see more of these companies generating significant revenue and yet constrained at the same time.

**Tremendous opportunities exist for geographic expansion for PPM companies in markets that are under-penetrated. Disease management opportunities abound, for example. Also, there are tremendous opportunities in selected niche markets, such as Medicare and Medicaid.**

ratios in those companies were extremely low. But there are examples in this group of companies that are very interesting.

One is Pediatrix in Fort Lauderdale Fla. In one way, this company, which focuses on the neonatology business, proves the lie to a rule many investment bankers have about focusing on big markets. Neonatology is about a \$2 billion market in this country, which by many standards is very, very big, but by physician services standards is a very tiny little market. Pediatrix is a company generating \$50 million in annual revenue and has \$850 million in market capitalization because it is a highly focused company with a long operating history, a clear and focused growth strategy, and by far it is the largest consolidator of neonatology practices in this country.

### Hospital-based Services

The point is this: There are plenty of opportunities for successful companies in hospital-based physician service disciplines. In addition, the independent practice association (IPA-model) is a good model in our observation but there are no pure-play companies that are publicly traded in this area. So, we will be looking in the private sector for companies that focus on IPA models.

In addition, there are tremendous opportunities for geographic expansion for PPM companies in markets that are under-penetrated. For example, disease management

forms those markets. We are excited about the workers' compensation business and the dental management business. Each of these markets and each of these models will evolve, and as they do, there are tremendous opportunities for investment.

### The Challenges Ahead

These nationwide opportunities notwithstanding, health care remains a local business and it is in the midst of a transition from a local concentration to a regional and national concentration. As managed care penetration increases, it changes every mar-

### Limits to Growth

One reason that many physician practices are constrained today is the lack of information systems infrastructure. As an investment brokerage firm, we are very excited about investment opportunities in health care information technology. But most of the physician executives I speak with report that they cannot buy what they need in information systems. If you are growing rapidly but you can't buy the information system you need to manage your business, that will create a serious hurdle to further growth. We believe that challenge will be met by venture capitalists and entrepreneurial information technology developers, but in the meantime, it presents a serious impediment.

Another barrier to growth is the limited business management talent that exists today in the health care business. With all due respect to today's aspiring entrepreneurs, we find it extremely difficult to find talented seasoned managers in health care, and that's going to be a limitation.

In conclusion, we think the explosive growth of PPM companies will continue. Quality companies will maintain their lead.

**Founded by a physician, OccuSystems is the largest consolidator of primary care physicians who focus on occupational medicine, which is a \$60 billion business that has had limited managed care penetration until recently.**

ket, and it's evolving in different ways in different markets. Physicians and investors, therefore, will need to be extremely nimble in these evolving markets.

One of the barriers to more rapid growth is the constraints of the existing infrastructure. I get calls from people all the time who are in businesses generating \$2 billion annually, and yet, they don't know how to grow beyond that level. As we go forward,

We are not in the camp of those saying that the opportunities have been tapped by the existing public companies. We think there'll be a wave, maybe many waves, of additional companies coming into this business. We do encourage physicians to invest with patience because of the cyclical nature of valuation in this business, and, in addition, we believe that significant opportunities remain. ■

# What It Takes to Remain Independent

## Part One: Expanding While Retaining Control

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

**Editor's note:** All physician groups seeking to operate profitably under managed care must find ways to access capital to build the necessary infrastructure and to recruit additional physicians. In the market today, physician groups are choosing one or a combination of three strategies:

1. Expanding independently while retaining control;
2. Selling to a strategic partner; or
3. Combining the equity interests of multiple local or regional clinics.

In this article—the first of three parts—we will examine the first option: expanding independently. Next month, we will discuss selling to a strategic partner. In the third installment, we will examine how clinics can combine equity interests.

### Expanding Independently

Often the path a group must take is dictated by operational and market dynamics. Before assisting a group in pursuing a particular strategy, the best advisers will analyze the internal and external dynamics of a clinic to determine which strategy is most feasible.

When physicians evaluate strategic alternatives they typically want to maintain their autonomy. Independence allows physicians to maintain ownership control, continuity in management and operations, and strategic flexibility to respond to changing market conditions. Most physicians, however, are unaware of the capital requirements and strategic business planning needed to pursue such an alternative. Groups that are most capable of remaining independent will have a strong desire for autonomy, strong leadership, discipline, capital, and retained earnings.

**A strong desire for autonomy.** First and foremost, the physicians must have a strong

desire to maintain autonomy. Typically, groups in which the average age of physicians is less than 45 years have a greater interest in the dynamics required to remain independent to maximize the value of the practice going forward.

**Strong direction and leadership.** The group must have a sound, well developed business plan endorsed by all physicians. At a minimum, the business plan must address the group's strategic plan to manage and sustain operations profitably under increased managed care. Clinic leadership

**Access to capital.** To operate profitably under managed care, significant capital investment is required to build infrastructure, create financial reserves, and to foster growth by recruiting additional physicians. This financing can come either from commercial lenders, strategic partners, venture capital firms, or from internally generated funds. Transactions with any of these partners could lead to reduced physician compensation or diluted governance and ownership control.

**Retained earnings.** Keeping earnings in

**In the future, physicians in groups must focus on maximizing income for their clinics rather than focusing on personal income. While annual personal income is important, more significant value can be derived from equity ownership in a clinic that has a sustainable business plan aimed at profiting from managed care.**

must be ceded to a select group of physicians and administrative personnel, usually in the form of a partnering committee or governance board. This group will be responsible for developing and executing the business plan, entering into strategic agreements, and responding to changing market conditions quickly.

**Financial and operational discipline.** To compete effectively and to negotiate successfully with payers, physicians must manage their clinics with the strong financial and operational discipline found in well run businesses. In the future, physicians in groups must focus on maximizing income for their clinics rather than focusing on personal income. While annual personal income is important, more significant value can be derived from equity ownership in a clinic that has a sustainable business plan focused on profiting from managed care.

the practice allows physician groups to grow organizational wealth without diluting governance or ownership. This strategy does, however, reduce physician compensation and may require time to build up the capital needed to adapt to changing market conditions quickly and effectively.

### Capital Partnering Options

Similarly, having a capital partner may allow control to remain with the physician shareholders but typically requires physicians to sacrifice some level of current income, and in some cases, equity ownership. Groups pursuing this strategy usually require moderate amounts of cash to fund specific needs, and they may want to leverage what's called the partner's intellectual capital, such as knowledge of and experience in building and operating managed care systems. Sources of capital for groups

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seeking to maintain their independence include the following:

**Commercial banks.** The commercial banks are the traditional sources of capital for physician groups, which generally have

Second, hospitals usually lack significant managed care expertise, which a physician group may want, and third, the hospital's need to fill beds is inconsistent with managed care.

Austin Regional Clinic (ARC) had successfully developed a business plan that called for significant investment in management information systems to accept capitated contracts in the heavily penetrated Austin market. Led by its president, Norman Chenven, MD, ARC historically had retained earnings and invested heavily in a talented and cohesive executive management team. Its strength as a business enterprise enabled ARC to move from an exclusive provider relationship to multiple non-exclusive agreements with several large HMOs. ARC has 112 physicians who care for more 75,000 managed care enrollees. In September 1994, the clinic announced that it had secured a line of credit for an undisclosed amount from Seton Hospital. ARC did not give up any ownership interest in the clinic or enter into any long-term contractual alliances with the hospital.

Health First, formed in 1993, historically had been financed with secured bank debt and money raised from physicians. The clinic's management had initiated a strate-

**Sourcing minority investment from a PPM company clearly brings the best of both worlds: a partner that understands clinic operations and has access to investment capital. Keep in mind, however, that a PPM company will be interested in turning its minority position into a majority ownership stake.**

historical business relationships with banks. These funds may be unattractive due to requirements for personal physician guarantees and a general requirement to start amortizing principal shortly after the funds are remitted. But these funds may be attractive because physicians generally do not need to surrender equity ownership.

**Venture capital.** Numerous venture capital firms have funds available for investment in properly positioned physician groups. When investing, these firms generally require rates of return higher than those required by commercial banks. Venture capitalists generally allow for longer repayment terms, however, or may forgive repayment in exchange for an equity stake. The biggest challenge in a venture capital partnership is determining a value for the clinic that will provide for the needed capital, yet keep the venture capital fund's percentage ownership below 50%. This form of capital partnership generally favors larger clinics that can support higher enterprise values in relation to the capital needed.

**Local hospital.** Many hospitals are looking to partner with physician groups in their area to create an integrated delivery system and so may be willing to invest capital with a well positioned group. Hospital partnerships create a strategic challenge for three reasons. First, there may be a conflict between physicians and hospitals over clinic management, an area in which hospital administrators have little expertise.

**PPM company.** Investment activity in physician groups by physician practice management (PPM) companies continues to accelerate. Sourcing minority investment from a PPM company clearly brings the best of both worlds: a partner that understands clinic operations and has

**Having a capital partner may allow control to remain with the physician shareholders but typically requires physicians to sacrifice some level of current income, and in some cases, equity ownership.**

access to investment capital. Keep in mind, however, that a PPM company will be interested in turning its minority position into a majority ownership stake. In many cases, a majority ownership position may be satisfactory if the enterprise value of the clinic has been enhanced over the same period.

### Two Successes

Two groups that serve as good examples for expanding independently are the Austin Regional Clinic, in Austin, Texas, and Health First Physicians in Denver, Colo. Each group successfully raised capital while maintaining ownership and control of the group's operations.

gic plan to increase the number of clinic physicians from 35 to more than 100 in one year. Significant capital was needed to fund physician recruitment and acquisitions and to develop managed care infrastructure. In May 1996, Health First announced that it had secured \$35 million in committed capital from TA Associates, \$1.2 billion venture capital fund in Boston. Health First will use the funds to acquire physician groups and to invest in managed care information systems.

While not all clinics will have the same success as ARC and Health First, their strategies illustrate that there are a variety of strategic alternatives available to physician groups. ■

## Average Physician's Pay Drops by 4%

The average doctor's pay fell in 1994 by nearly 4% to \$187,000, possibly a result of patients moving to managed care from traditional insurance, according to an article in *Health Affairs*, a health policy quarterly published by Project Hope, in Bethesda, Md. The drop in pay suggests managed care was cutting reimbursement to doctors and curbing patient access to physician services, Project Hope said. Other factors were a shift toward group practice and cuts in Medicare reimbursements.

The drop in 1994, the last year for which figures were compiled, from the 1993 average was the first time physicians' earnings had fallen since income statistics were first collected in 1982, the article said. Until 1994, the average physician's income had risen nearly 6% a year, or 2.2% annually after adjusting for inflation, said the authors, Carol Simon, an associate professor at the University of Illinois at Chicago, and Patricia Born, an AMA economist. In 1995, more than 83% of all doctors had at least one

fee-limiting managed care contract, up from 61% in 1990 and 43% in 1986, the article said.

Citing earnings statistics compiled by the AMA, the article said average pay dropped for primary care physicians by 1.7% to \$129,353; for hospital-based specialists such as those in anaesthesiology and emergency medicine by 4.6% to \$214,634; for subspecialists in internal medicine by 5.1% to \$243,828; and for general surgeons, psychiatrists, and those in obstetrics and gynecology by 5.3% to \$179,072.

**Comment:** At least 12 organizations track physicians' income for 14 different specialties and all use different methods, according to *Modern HealthCare* magazine (July 15). By taking the mean compensation from the 12 surveys, internal medicine (up 6.6%), general surgery (up 4.8%), family practitioners (up 4.5%) won the biggest gains, and oncologists (down 5.2%), anesthesiologists (down 5%), and pathologists (down 3.5%) lost the most. ■

## Report Cites Potential of Disease Management

Disease management has the potential to bring together pharmaceutical companies, managed care organizations, and pharmacy benefit managers (PBMs) into new levels of cooperation, according to a new study, titled *Disease Management: Fact and Fiction 1996*, by health care consultants Scott-Levin, in Newtown, Pa.

As a cost control and quality-improvement strategy, particularly for chronic care cases, disease management shows promise, the study shows. Administrators of disease management programs, however, have several hurdles to overcome, the report says.

The strategy depends on sharing of appropriate data among health care providers, for example. Yet many managed care companies are reluctant to share such data, the study says. One-fifth of pharmacy directors say they have yet to address data-sharing issues. PBMs, which do much of the work involved in disease management, have limited access to diagnostic information and test results. Yet more than a third (36%) of pharmacy directors responding to the survey say they do not plan to implement disease-management pro-

grams for chronic conditions.

Moreover, disease management has great potential to improve quality and control the costs of long-term care, yet few managed-care executives said they were planning to apply disease management to that market.

The study results are based on responses to a questionnaire from 19 medical directors, 36 HMO pharmacy directors, and 1,060 physicians across 22 specialties. Also, Scott-Levin conducted telephone interviews with PBM executives, employee benefit managers, nursing home consultant pharmacists, home infusion executives, and state Medicaid administrators.

**Comment:** The pharmaceutical industry has seized on disease management as a way to enter the managed care arena, but other observers believe the strategy is an example of how all the tools of managed care, including clinical guidelines, quality measurement, outcomes management, utilization review, and patient education, can be used together to produce the best results at the lowest cost. Disease management also offers a significant opportunity for specialty physicians seeking to use their expertise to produce better outcomes. ■

## Number of Medical Oncologists Just About Right

Despite concerns that the United States has an oversupply of medical specialists, the nation has the appropriate number of medical oncologists, according to a survey conducted by the American Society of Clinical Oncology (ASCO). Reported in the September issue of *The Journal of Clinical Oncology*, the survey results suggest that there are 1.8 medical oncologists per 100,000 U.S. adults, about the number HMOs estimate is needed.

The results show that physicians employed by HMOs saw somewhat more patients than those in traditional private practice. In the 30 days before the survey was completed, physicians working in HMOs saw 226 patients on average; private practice physicians saw 213.5 patients; community and hospital-based physicians saw 150.2 patients; and medical school and university physicians saw 91.5 patients.

**Comment:** For practice management firms, medical oncologists have been the most attractive acquisition target among medical specialists. The reasons most often cited are that medical oncologists are believed to be one of the few specialists in short supply and the demand for them will grow as the population ages. The survey results now throw the first reason into question. ■

## NEWS AND COMMENTARY

### Provider Service Networks Get Federal Support

The Federal Trade Commission and the U.S. Justice Department have issued new guidelines to allow doctors to form networks and joint ventures to compete with insurers and HMOs. By contracting for patients directly with employers and the government without an HMO, insurance, or other intermediary, physicians expect to take some control of medical decision making and keep more of the income they generate.

Provider-service or physician-sponsored networks (PSNs) are an emerging option in sophisticated managed care markets. Both physicians and health care buyers want to eliminate the middleman, such as HMOs, insurers, and third-party administrators, in an effort to cut costs.

Insurers, managed care plans, and their trade organizations, such as the Health Insurance Association of America and the American Association of Health Plans, oppose PSNs because they fear they will lose market share to physicians contracting directly with payers. Insurers and HMOs are required to retain certain assets to protect consumers against catastrophic losses and bankruptcies. The PSNs have so far had no such requirements. For this reason, state insurance commissioners oppose them, saying that if physicians accept the financial risk of providing care, they are, in essence, insuring plan participants and should then be required to meet the same requirements as insurers.

**Comment:** Russell Coile Jr., president of the Health Forecasting Group, in Santa Clarita, Calif., says PSNs essentially create a new form of managed care organization. The change is expected to accelerate the formation of physician networks, particularly those in which doctors do not share financial risk. ■

### 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. In a search for new practice options, physicians are asking themselves a variety of questions, including:

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

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