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Under New Rules, PSOs Offer Significant Opportunities, But Experts Advise Caution

For physicians seeking new organizational options, the recently enacted Balanced Budget Act of 1997 may be among the most significant legislation ever passed. Signed into law in August, the act allows provider-sponsored organizations (PSOs) to function like HMOs, without the solvency requirements now imposed by the states.

Physicians should proceed carefully, say experts familiar with the legislation. When considering a PSO, for example, physicians should ensure that reimbursement rates will be high enough to ensure a profit. Also, physicians should be aware that a new PSO would compete with existing managed care organizations (MCOs) and thus could jeopardize current referral patterns.

"It can be an extremely important opportunity for physicians, but it's not without dangers," says Peter Grant, the head of the health law division of Davis Wright Tremaine, a law firm in San Francisco. "There is no question that physicians who are unskilled in financial matters and in how capitation systems operate, and who do not examine their practice options carefully, could be putting themselves in danger in responding to this legislation," Grant continues. "For physicians who seek and receive sound information and advice, these risk-assuming PSOs could offer significant financial advantages. They should move quickly but carefully to take advantage of the act's provisions."

The act expands Medicare by creating the Medicare+Choice program, which, beginning in 1999, allows all Medicare recipients to choose to enroll in managed care plans, including risk-assuming PSOs. More important, the law exempts PSOs from state financial solvency regulations that, until this law was passed, made it financially difficult for physicians to provide managed care services in organizations they owned and ran themselves. PSOs also are commonly referred to as provider-sponsored networks (PSNs).

One complicating factor in the act will be the effect on physician reimbursements under Medicare fee-for-service payments, which will fall for two reasons. First, the act cuts $115 billion from the Medicare program and $13 billion from Medicaid; second, it changes the way Medicare pays MCOs by revising the adjusted average per capita cost (AAPCC) rates. AAPCCs currently range from $240 per person per month (PMPM) in rural markets to $700 in urban markets. The legislation sets a national floor of $367 PMPM, but generally increases rates by only 2%.

"The issue of AAPCC rates is one physicians should consider carefully," Grant says. "In some markets, it would make no financial sense to set up a risk-based PSO because of the flat AAPCCs."

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> "How PSOs are eventually defined will determine how these entities are organized and run. The law states that physicians can run these organizations themselves as long as they put a substantial portion of the PSOs' participating providers at risk."
>
> — Peter Grant

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EDITORIAL

Capitation Rules of Thumb

Readers often tell us that capitated contracts are among the most troubling issues they face. How can they evaluate whether the proposed rates are reasonable, they ask. What kind of information system will they need, if any? What pitfalls should they avoid? What type of capitation should they consider: primary care, specialty care, global?

Typically we refer readers with such questions to our editorial Advisory Board, many of whom are experts in capitation. Recently I asked the board to outline capitation issues in general and to offer rules of thumb for physicians considering such contracts. Here's what they said:

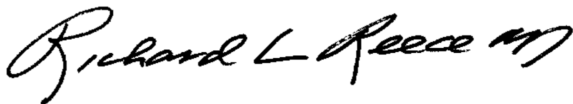
- Since capitation represents less than 20% of total physician revenue and global capitation represents just 4%, specific issues regarding this reimbursement system involve understanding the particulars of the market in question.
- Capitation is more prevalent in the West than anywhere else. Capitation is much less common in the East, South, and rural areas, in markets dominated by PPOs, and in places where physicians practice in groups of fewer than four members.
- Capitation does not necessarily dominate in mature markets, such as Minneapolis and Boston, for three reasons. First, self-insured employers are unwilling to transfer revenue to risk-bearing providers. Second, significant penetration of point-of-service plans makes capitation impractical because plan members can seek care from out-of-network providers that are not capitated. Third, capitation is irrelevant when most physicians are employed by systems or institutions.

For physicians considering capitation, the board offered five specific recommendations:

1. Keep an open mind. Capitation rewards physicians in well-managed practices with large numbers of covered lives. Therefore, many primary care physicians report receiving higher margins from capitated contracts than from fee-for-service.
2. Recognize that fee-for-service payments from all sources will continue to shrink. Capitation should not be avoided because it may be the sole alternative available some day.
3. Invest early on consultants who can determine if a capitation contract makes sense. HMOs often issue proposals based on what a market will bear, not on actual utilization and costs. Also, a good consultant should know how to uncover hidden costs.
4. Use the law of large numbers. If the proposal doesn't provide 300 to 500 enrollees per PCP, you're placing yourself at risk.
5. Evaluate the scope of services. One internist signed a contract without noticing his obligation to provide sigmoidoscopy services for other network physicians. In the next year, he spent half of his time doing the procedure for free for other doctors.

The board also offered several "don't do" guidelines for physicians: Don't leap to accept global capitation. Don't count on balanced billing to make up for lost fee-for-service income. Don't think of capitated enrollees as patients since you may never see 90% of them; but when you do see them, provide superb service because healthy patients help pay the bills. In markets in which managed care is not well established, don't invest heavily in information systems for capitation. If you're a specialist, don't accept capitation.

For readers who have other questions regarding capitation, we will seek to answer them or refer you to someone who will.



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Managed Care Moves Into New York City

Bucking a tradition of independence, a rising number of New York City physicians are forming or joining medical groups, or selling their practices to physician practice management companies (PPMCs). The force behind these changes is increasing managed care market penetration.

"This is a part of the country where doctors resist change and remain independent as long as they can," says Susan Tucker, director of government affairs and medical economics for the New York County Medical Society. "But even in New York City, doctors are feeling the effects of managed care. There aren't a lot of medical groups here, but our membership is expressing an increasing interest in practice alternatives."

John Connolly, former president of New York Medical College and a director of the New York Business Group on Health, both in New York City, says he sees an increasing level of group formation activity. "A large number of physician group formation initiatives are under way. Every week I run into a new group seeking capital or a management company seeking a new group," he says.

Changes are occurring slowly and arduously, in part, some health care executives say, because New York and the city in particular are 10 to 15 years behind many other parts of the country in terms of managed care growth.

Some 23,000 physicians practice in New York City's five boroughs. Of those, Tucker estimates that about 2,500 are members of the 22 medical groups in New York City. About two-thirds of those groups are multispecialty groups, Tucker says. In California, more than 50% of physicians belong to multispecialty groups of 100 or more, and in Minnesota, 30% are members of such groups. In the United States, there are more than 1,000 medical groups of 25 physicians or more, according to the American Medical Association. But even the comparatively low percentage of group practice activity in New York City is a significant change: It is more than twice as much as there was five years ago, Tucker says.

The number of PPMCs doing business in the city is difficult to determine, according to the State Medical Society of New York, but PPMC activity is increasing. "Physician practice management companies are active in New York," Connolly says. "They've jumped in with a vengeance to organize area doctors. Because there are few preexisting large groups, we're not seeing massive physician organizations developing like they are in other parts of the country, so management companies and physician leaders basically have to organize one doctor at a time. Physicians are organizing within their own specialties and into multispecialty groups to leverage themselves so they can better negotiate with HMOs or PPMCs." The nation's two largest PPMCs—MedPartners, in Birmingham, Ala., and PhyCor, in Nashville, Tenn.—are increasingly active in New York City, he says, and have approached several of the city's multispecialty groups.

> "We are our own worst enemy. We're late in the managed care game because we think differently. We still believe in what brought us to the dance: specialization, affiliation with academic centers, our ability to conduct our own businesses, to master any field of knowledge, and to understand the financial world. We may be too smart for our own good."
>
> —William R. Grace, MD

A Painstaking Process

Group formation in a market that has long resisted change is painstaking and time consuming, says William R. Grace, MD, an oncologist who practices alone in Manhattan near St. Vincent Hospital and Medical Center. Grace has worked nearly three years toward establishing a multispecialty management services organization (MSO). "We [physicians in New York City] are our own worst enemy," Grace comments. "We're late in the managed care game because we think differently. We still believe in what brought us to the dance: specialization, affiliation with academic centers, our ability to conduct our own businesses, to master any field of knowledge, and to understand the financial world. We may be too smart for our own good.

"This is a tough competitive city," Grace continues. "As physicians, we've done well as specialists in fee-for-service; so why change? We're risk adverse. We think we should know everything about everything, and we're individualists who don't blindly or even intelligently follow our leaders. But we understand our patients and we understand price, and we'll do what we have to do."

As it increases statewide, managed care penetration also is increasing in the city. Some 6.2 million residents in the state were enrolled in HMOs as of last year, up from 2.8 million in 1990. In New York City, HMOs currently insure at least 25% of the 8 million residents, and that proportion may rise to 40% within the next two years, according to estimates from the state medical society. Large group-model HMOs—such as Kaiser Permanente, in Oakland, Calif., and HIP in New York City—are courting enrollees aggressively, and some network-model HMOs—including Oxford Health Plans, in New York City; Aetna-U.S. Healthcare, in Hartford, Conn.; MetraHealth, a division of United Health Care in Minneapolis; PruCare, in Newark, N.J.; Cigna, in Bloomfield, Conn.; NYLCare, in New York City; Physicians Health Services, in Norwalk, Conn.; and Empire Blue Cross and

Blue Shield Plans, in Albany—are growing rapidly in the state and the city, says the state medical society.

Oxford, which insures more than one million residents in New York State, has been particularly effective in penetrating the city market. Oxford has begun to offer alternative medical services, has introduced a project at Columbia University to pay nurse practitioners the same as physicians for primary care, and is initiating a plan to pay case rates for many expensive or high-volume conditions. Salick Health Care, a company in Los Angeles that cares for cancer patients under capitation contracts, is marketing its services aggressively. The cost of cancer care in New York State each year is estimated at $4 billion.

Distrust of the Inevitable

New York Doctors MSO, a 1,000-member PPMC in New York City, surveyed city physicians about their experience with managed care earlier this year and found that about half of the respondents viewed managed care as having a negative effect on their practices. But nearly three-fourths of the 200 responding doctors believe managed care is here to stay. Although the sample size was small, the results indicate that at least some physicians are concerned about managed care.

"These are alarming trends that reflect physician concerns about the quality of patient care under the managed care system as it now exists in Metropolitan New York," says Richard Sanchez, MD, the CEO of New York Doctors MSO. "But physicians want change, especially primary care physicians who are in the front line of medicine and are feeling increasingly overburdened by paperwork, administration, and negotiating responsibilities under managed care. Perhaps most troubling of all, they feel they are being forced to spend less time with their patients." More than half of the surveyed physicians, Sanchez says, "believe the best way to spend more time with patients versus dealing with insurance companies is to contract with an MSO or a PPMC."

Besides wanting to find administrative alternatives to the time and cost demands created by managed care reporting requirements, city physicians are facing decreasing reimbursements, says Kenneth Abramowitz, a health care analyst at Sanford Bernstein & Co., a financial management firm in New York City. "Pricing is the one thing doctors invariably respond to, and in New York City doctors' fees have always been very high. Traditionally, in New York City, doctors have been the muscle guys on the beach. No one challenged them, so they kept doing what they had been doing: practicing as individuals and avoiding group affiliations. In essence, city doctors were begging for a market crisis to tell them how to behave. Well, the market is telling them to join groups, to drive their overhead down, and to deliver lower cost care. I believe in the multispecialty group concept, no matter who does it, and I believe these groups will be the way care is delivered in the future," Abramowitz says.

On Jan. 1, the New York State Legislature deregulated the state's hospitals, effectively ending three decades of rigid price controls and state-supported expansion projects. Also, New York City Mayor Rudolph Giuliani has introduced a hospital privatization plan and wants to shepherd 1.2 million Medicaid recipients into managed care.

"The hospital privatization issue has definitely moved from the back burner to the front burner," says Kenneth E. Raske, president of the Greater New York Hospital Association. Under a privatization plan, Giuliani would shift ownership of 11 city hospitals to private companies. "This shift to for-profit practice management and hospital firms is likely to force doctors to consolidate into groups or to be consolidated by the PPMCs," says Raske.

Despite the changing market dynamics, New York City physicians have yet to realize how much they need to change, says Daniel Ratner, president of Physician Capital Corp., in Tarrytown, N.Y., that helps physicians fund group practices. He is helping to establish a Manhattan multispecialty group and says the health care culture in New York City can have an adverse effect on the ability of physicians to work with investors. "New York City physicians think they can get capital easily, without going through all the steps necessary to qualify for that capital, like developing the ability to accept risk," he says. "They find it psychologically difficult to deal with the roll-out of the process and all the players outside their immediate area of expertise."

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> **— John Connolly**

A Successful Effort

But persistence and trust can pay off. Michael Bruno, MD, chief of the department of medicine, and colleagues at Lenox Hill Hospital have been working with Advanced Health Inc., a PPMC in Tarrytown that has spent two years organizing a 33-member multispecialty group in Manhattan. The group, The Madison Medical Group, has leased a three-floor 60,000-square-foot space at 110 East 59th St. The group has its own laboratory and radiology facilities and offers various ancillary services. The physicians have learned that by integrating they have much greater potential value to PPMCs and can be an important vehicle for attracting managed care contracts.

"Doctors are smart people," Connolly says. "They know they have to belong to HMOs to maintain their practices, but they don't like HMOs and why should they? HMOs cut their fees, monitor their quality, and add to their business expenses. Adapting to managed care for them isn't as easy as it is for physicians in the West or Midwest, where doctors were in large group practices. The New York Metro region has been slow in accepting managed care and has resisted it strongly. But physicians know HMOs are breaking down the gates, and resistance is rapidly collapsing.

"At coffee conversations in staff lounges, physicians constantly talk about forming organizations," Connolly adds. "Right now, managed care is the engine driving the health care train in New York City. Until recently, physicians have been in the caboose. It's a time of the most incredible change in health care in New York City that I've ever seen. There's a huge pent-up demand for cost-lowering techniques and with deregulation, we'll see the for-profit enterprises bringing enormous capital into the city and the state." ■

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Markets that have several existing Medicare-risk plans, such as those in urban areas of California and Minnesota, may not be well suited to new PSOs, Grant says. "Going into competition with those plans could create an adversarial relationship with entities physicians now have beneficial referral relationships with," he explains.

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>
> **— Carol S. Jimenez**

Under the act, a PSO is defined as a health care delivery system organized and operated by providers (see page 7: "Definition of a Risk-assuming PSO"). A risk-assuming PSO contracts with the Medicare program to provide services at a set, prepaid fee per month, a form of reimbursement known as capitation. If the fee is greater than the cost to deliver care, the PSO profits. If not, it loses money.

Individual physicians paid on a capitated or other risk basis also assume risk. But most physicians and physician groups cannot afford the information systems and administrative infrastructure required to manage risk on their own. Therefore, they form organizations, such as PSOs, to create the required economies of scale and to pay for adequate infrastructure. Before the Balanced Budget Act was passed, these organizations could not accept managed Medicare patients unless they met two, often difficult, requirements of federal law: They had to be licensed by the states in which they had enrollees and they had to comply with the so-called 50-50 rule. Under federal Health Care Financing Administration regulations, the 50-50 rule requires at least half of all enrollees in the health plan to be commercially insured. The act eliminates the 50-50 rule and the necessity of state licensure.

Solvency Requirements

The state licensing issue involves financial solvency requirements imposed by the insurance departments in each of the 50 states on all risk-assuming entities, such as insurers or HMOs. Under state

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solvency requirements, risk-assuming entities must put up $1 million or more to protect consumers in case the entity fails. The act allows the federal Department of Health and Human Services (HHS) to license PSOs to assume the financial risk of delivering care under certain conditions.

Under the act, HHS must publish PSO solvency standards. The AMA's Office of General Counsel explains that in establishing these standards, HHS will consider the delivery system's assets; its ability to provide services directly to enrollees through affiliated providers; any alternative means of protecting against insolvency, such as reinsurance; and any standards developed by the National Association of Insurance Commissioners (NAIC) specifically for risk-based health care delivery organizations. Since the NAIC has strongly opposed waiving the state solvency requirements for PSOs, the requirement that HHS consider any NAIC requirements is important, explains Grant. "PSOs have lower financial reserves than insurance companies, and that's what gave the NAIC some concern," he says. A concern that may now diminish because, as Grant says, "the law states that a PSO can include its assets, not just liquid cash, to establish its solvency."

But the Blue Cross Blue Shield Association, in Washington, D.C., has expressed concern over whether allowing PSOs to include professional assets, such as medical equipment, as proof of solvency adequately protects consumers. "It is important to emphasize that, from a consumer's point of view, there is nothing unique about PSOs that warrants exemption from state licensure consumer protections related to quality of care and solvency," says Carol S. Jimenez, an attorney in Long Beach, Calif., who has written on the subject for the association. "Consumers enrolled in PSOs need the same level of protection as those enrolled in HMOs. It is critical that PSOs comply with the broad variety of consumer protections enacted by states, including quality assurance protections, disclosure of information requirements, financial solvency rules, coverage of basic health care services, and grievance procedures for enrollees denied needed care, and be subject to periodic monitoring by a local licensing or regulatory agency."

> **"State regulations do not fit the operations of health care providers. They normally do not maintain liquid assets. But that does not mean they are in danger of becoming insolvent. Their assets are in health care delivery, and they have the capacity to deliver the services for which they assume risk."**
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Richard Corlin, MD, a gastroenterologist in Santa Monica, Calif., argues that studies have shown physicians can provide quality care in capitated settings. "Solvency standards should reflect the unique characteristics of PSOs," Corlin said in testimony before Congress earlier this year. Corlin is a member of the House of Delegates, the AMA's ruling body.

"There are dramatic differences between provider organizations that assume risk and insurance companies," Corlin said. "Provider organizations exist for the primary purpose of delivering health care services to patients. To the extent that they enter into risk-sharing arrangements, they do so for the primary purpose of delivering health care. The assets of providers that enter risk-sharing arrangements are concentrated in health care delivery.

"In contrast, the primary purpose of an insurance company is to profit by underwriting risk," Corlin continued. "They do not deliver health care services. Their assets are in liquid securities. State regulations do not fit the operations of health care providers. They normally do not maintain liquid assets. But that does not mean they are in danger of becoming insolvent. Their assets are in health care delivery, and they have the capacity to deliver the services for which they assume risk. That does not mean that provider networks can sustain substantial and unexpected catastrophic loss, but they can sustain themselves longer without liquid reserves because of their health care delivery assets."

HHS's solvency requirements, which must be published by April 1, 1998, will be designed to take into account the unique nature of a provider-owned delivery system, says Beth Morrow, an attorney with William M. Mercer Inc., health care consultants in New York. "The inclusion of these new standards was an important victory for providers, which wanted assurances that they would not be subject to state solvency requirements," Morrow says.

> **"There is no question that physicians who are unskilled in financial matters and in how capitation systems operate, and who do not examine their practice options carefully, could be putting themselves in danger in responding to this legislation."**
> **— Peter Grant**

Ownership and Affiliations

The law requires physicians and other health care providers to have at least a majority interest in the risk-assuming PSO, and they must provide a substantial portion of health care services directly. A key element of the legislation, however, is that the owner-providers, who have a majority financial interest in the PSO, must share substantial financial risk with other physi-

Definition of a Risk-assuming PSO

A report from the AMA's Office of General Counsel explains the implications of the Balanced Budget Act of 1997 for physicians. It defines a provider-sponsored organization (PSO) and outlines the federal role in licensing these organizations. The report, *Provider Sponsored Organization Provisions in the Balanced Budget Act of 1997,* says the act defines a PSO as a health care delivery system established and operated by a health care provider, or a group of affiliated providers. The PSO must provide a substantial proportion of the health care services directly through its member providers or an affiliated group of providers. Some affiliated providers must share substantial financial risk in delivering care. A health care provider is defined as an individual or entity engaged in health care delivery and licensed or certified by the state.

The definition of "substantial proportion" will be determined by the federal Department of Health and Human Services by April 1998, the AMA report says. At the least, HHS will require PSOs to assume responsibility for providing "significantly more than the majority" of the services provided through its own affiliated providers. HHS, however, may allow some flexibility in the substantial proportion requirement because of location, such as in rural areas where a PSO may need to use out-of-network physicians to provide services.

State and Federal Jurisdiction

Both federal and state governments will have jurisdiction over PSOs, the AMA report says. Although the act requires that risk-assuming PSOs be certified under federal law, one prerequisite for federal certification is state licensure. State solvency standards will be superseded, however, by those established under the act if the state rules are inconsistent with federal standards. State standards relating to benefit requirements, the inclusion of providers, coverage determinations, and appeals and grievance procedures also will be superseded by federal law.

If a PSO applies to HHS by Nov. 1, 2002, it could get a waiver exempting it from state licensure. When applying, the PSO would need to show that the state failed to act on a timely basis on a substantially complete application or it required documents different from those required by HHS. It would also need to show that the state denied an application based on discriminatory treatment or solvency requirements that differ from those established under the law.

Although a PSO may obtain a waiver exempting it from state licensure requirements, such waivers can last no longer than 36 months and will not be renewed. HHS can recommend that the waiver process continue after Dec. 31, 2002, if expiration of the waiver is shown to have a negative effect on beneficiaries or the long-term solvency of the program, among other factors.

A PSO holding a federal waiver from state licensure requirements must still comply with all state consumer protection and quality standards, as long as the state standards are consistent with those of Medicare. After the waiver period is over, a PSO will once again be subject to state licensure requirements. At that point, state solvency requirements will apply as long as they are not inconsistent with the federal standards established under the act.

cians and health care providers, Grant says. That provision means PSOs must create risk-sharing relationships with such providers as medical groups, hospitals, or specialists that are hired to deliver services.

HHS's interpretation of "substantial financial risk" will be extremely important to providers in determining what types of risk-sharing arrangements to enter when they establish a PSO, Grant explains. "How such terms are defined by HHS will determine how these entities are organized and run," Grant says. "The law states that the doctors can run these organizations themselves as long as they put a substantial portion of the PSOs' participating providers at risk. That is a major reason why these PSOs should work."

When forming a PSO, physicians can become partners with other entities as long as health care providers own at least a majority financial interest, and the providers can affiliate with any number of different types of entities, including insurers or practice management companies, Grant says. The language defining a PSO implies that physicians could partner with an insurer, as long as the insurer company has only a minority interest, says the AMA.

The law also implies that PSOs must partner with hospitals, the AMA says. "If an entity is required to provide 'significantly more than a majority' of items and services through its own affiliated providers, this would suggest that a PSO must encompass hospital providers, as the majority of health care costs incurred in this country today are from hospital stays," the AMA says. But the law also suggests that a hospital need not be a full partner for a group of physicians to endeavor to form a PSO as long as physicians enter contractual arrangements with a hospital through which substantial financial risk is shared and a substantial proportion of health care items is delivered. HHS must clarify the term "substantial financial risk" so that physicians will be comfortable that certain contractual arrangements with hospitals will qualify them as being affiliated with a hospital, the AMA says.

The law does not specifically bar physicians from entering into fee-for-service arrangements with PSOs, but its provisions "greatly limit the extent to which participating physicians can be paid by a PSO on a fee-for-service basis," the AMA says. "Since fee-for-service contracts do not involve the sharing of risk, a [PSO] holding too many fee-for-service contracts will not satisfy the 'sharing substantial financial risk' requirement."

A significant amount of clarification will be needed by HHS on these issues over the next year to determine exactly how PSOs will be licensed and how they assume and share financial risk, Grant says. "I expect these entities to proliferate," Grant says. "But how they will be structured has yet to be fully defined." ■

Harvard Professor Recommends 'Focused Factories' for Health Care

Regina Herzlinger, PhD, *is the Nancy R. McPherson Professor of Business Administration at the Harvard Business School and the author of* Market-Driven Health Care: Who Wins and Who Loses in the Transformation of America's Largest Industry *(Addison-Wesley, Reading, Mass., 1997), which was in its fifth printing in July. An author and consultant who writes frequently about management control and health care, Herzlinger has been analyzing health care for 25 years as a researcher and professor. Before joining the faculty at Harvard, she was a management consultant for state and federal governments and served as the assistant secretary of the Office of Human Services for the Commonwealth of Massachusetts. She received a bachelor's degree in economics from the Massachusetts Institute of Technology and her doctorate in management control and information systems from the Harvard Business School. This interview was conducted by Richard L. Reece, MD, editor-in-chief.*

Q: *Congratulations on your book* Market-Driven Health Care. *It is being discussed widely among physician leaders, in part because it offers an alternative approach to the current system of health care rationing and managed care organizations run by large corporations. What led you to write the book and what audiences were you trying to reach?*

A: You've made my day because the audience you describe is precisely the audience I wanted to reach, mainly health care providers. If it strikes a sympathetic chord with enough providers, I hope that it will reach the political community and consumer thought leaders.

Q: *Several specialty physicians have called me and expressed an interest in your concepts, particularly your idea of focused factories, a term you use widely in the book (see sidebar). These physicians were interested in creating specialty carve-out variations on that idea. For that reason, I would like to dwell for a few minutes on this concept of focused factories and how these factories differ from what practitioners are doing now.*

A: First of all, they're not specialty carve-outs. These focused factories deliver health care services that are packaged from the consumer's point of view. A consumer with a medical problem is interested in getting the solution for that medical problem. The popularity of so-called alternative medicine—where the amount of money that's spent out of pocket by consumers to visit alternative medical providers is greater than the out-of-pocket spending on traditional providers—is because many consumers don't get the solutions for their problems. They see alternative providers for these problems because we don't have enough of a system to help them deal with their problems, which mostly are for chronic diseases.

Therefore, early focused factories will be in chronic diseases and they'll integrate a team of providers from many different specialties, including nonphysician providers, such as nurses and pharmacists, and health behavior specialists. These providers will focus on caring for the customer's chronic disease and all the comorbidities that go with that disease.

Another kind of focused factory, which is somewhat specialty-based, concentrates on a particular surgical procedure or a particular disability. Examples include the Denton Cooley Center in Houston, which focuses on coronary artery bypass grafts; the Shouldice Hospital in Toronto, which focuses on hernia surgery; and the Texas Back Institute, which focuses on athletic injuries to the shoulder and knee.

Q: *You also mentioned the Mayo Clinic as a focused factory.*

A: Right. Another area in which consumers don't get satisfactory treatment is in the diagnosis of problems, and Mayo is very good as a diagnostic facility. The principles the Mayo Clinic uses should be replicated elsewhere by organizations focused on diagnoses. Also, I don't see any problem with organizations focusing on acute care. Therefore, I see a whole panoply of focused factories, but the real crying demand is for those that deal with chronic diseases and those that specialize in specialty features.

Q: *Do you regard specialty physician practice management companies (PPMCs), let's say in oncology or ophthalmology, as a variety of focused factories?*

A: Oncology, perhaps; ophthalmology, no. Oncology focuses on cancer, and to the extent that PPMCs integrate all the different specialties required for the appropriate management of cancer, such as radiologists, surgeons, behavioral therapists, psychiatrists, and psychologists, and all the aspects needed to help patients manage this terrible disease appropriately, then they are a variant of a focused factory.

The ophthalmology network is a specialty-oriented system. Patients don't want ophthalmology. They need very good cataract surgery or they need ophthalmology because they have diabetes, in which case they ought to be treated in a diabetic focused factory.

Health care today is not organized by provider. It's like a department store that's organized by what buyers are expert in buying. So, a department store might have one department with towels, one with hardware, and another with bathroom fixtures because those departments have buyers who are specialists in those different areas. But what consumers want is a department that enables them to fix up their bathroom, bedroom, or living room, and they're not interested in the expertise of the buyers. They want the store to combine that expertise in a way that enables them to get what they need.

The ophthalmologist is the old way of doing things, but if it's a true focused factory and not just a group of oncologists, the oncology network is a new way of doing things.

Q: *So it's consumer- and disease-focused rather than specialty-focused, such as those organizations that are forming in the musculoskeletal arena to serve all patients with all problems related to musculoskeletal systems.*

A: Exactly. Some 40% of disabilities are caused by arthritis, rheumatism, or back or spine problems, and disabilities not only cost a lot of money directly in health care expenses, they're also tremendously costly in terms of losses in productivity, which I think is a legitimate consideration when looking at the cost of the health care system. Yet, there are few systems to which people with back or spine problems can go that will provide the many different ways of tending to their needs. Therefore, you're right: The musculoskeletal organizations are an example of a response to the consumer's need for complete treatment for that kind of disability.

Q: *Your idea also encompasses such chronic diseases as asthma, a disease that lends itself to comprehensive care.*

A: Not only comprehensive care, but also diseases in which self-care and preventive care will avoid many future problems. Frequently, diabetics and asthmatics don't get the diagnostic care and the support for self-care that they need because they visit internists or general-purpose physicians who don't have the expertise, the time, or the focus to invest in teaching diabetics and asthmatics how to monitor and care for their disease.

A study in JAMA, for example, showed that only 16% of elderly diabetics received an annual glycosylated hemoglobin exam. Focused organizations have incentives to invest in appropriate self-care and in the best diagnostic and monitoring systems because doing so will help them avoid significant expenses downstream.

Here's an example: Yale-New Haven Hospital set up a focused asthma unit. By teaching asthmatics to care for themselves, it reduced the rate of admissions to the emergency room and to the hospital by 60%. Many asthmatics are not complying with their physicians' instructions and many don't know how to use their inhalers properly, both of which create lots of problems.

Another example came from a physician in Hawaii who wrote to me. He headed a diabetes focused factory and claims he reduced the rate of renal dialysis over four years by 50%.

Q: *I heard another example. A doctor in Dayton, Ohio, organized 100 obstetricians and gynecologists into a capitated specialty network and he says the network reduced the number of procedures, such as hysterectomies and cesarean sections, by 56%.*

A: That's fantastic. I'm looking for examples of this concept. It's obviously powerful because that's how the U.S. economy reorganized itself. We used to have large manufacturing companies that did everything themselves. When the economy globalized, these everything-for-everybody firms got beat up. Then, the ones that succeeded became very focused. We used to have department stores that had everything for everybody, and, once again, the ones that succeeded became very focused. It's clearly a model that works elsewhere in the economy, and I'm sure it will work in health care.

Q: *In your book, you propose three diets for the health care system. One is downsizing, which is managed care. Another is up-sizing, which is large vertically integrated systems. And the third is right-sizing, which is trading fat for muscle.*

A: Right. That's the focused factory.

Q: *I gathered you believe that managed care and large vertically integrated organizations, which are generally hospital-based, are unpopular with consumers.*

A: Managed care and large vertically integrated organizations are not going to survive, but for different reasons. Consumers don't like managed care, and consumers and providers are heading to the legislatures and to journalists and they're saying, 'That managed care organization is a nasty thing. It won't let me have a bone marrow transplant for my breast cancer and I'm dying, and it won't let me spend an extra day in the hospital, and I'm so tired. I just had my baby and I need it.' And on and on.

Therefore, the iron triangle—of consumers, journalists, and legislatures—is conspiring to make it impossible for managed care organizations to control costs by passing laws to restrict the ability of managed care to set limits. Take, for example, the requirement that managed care plans keep new mothers in the hospital for 48 hours instead of 24. An extra day in the hospital, when there are 4 million births in the United States every year, translates into 4 million extra hospital days. That's a big-bucks item. Every single mandated requirement for coverage by HMOs is very expensive.

The result is that HMOs simply will be unable to compete as cost-effective organizations. Moreover, they have high costs for managing care. The administrative expense of straight indemnity insurance is 6%. But the administrative expenses of an HMO are at 11%, and if HMOs can't control their medical loss ratio because legislatures restrict their ability to set limits, and they have high administrative expenses, they quickly become uncompetitive and fail.

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Vertical integration is another great idea but it's not feasible. I wish it weren't so, but I've looked at almost every industry in every developed country, and in all of them, vertical integration does not work. The only time it has succeeded is in the early stages of an industry. In the automobile industry in the 1920s, for example, there were so few external suppliers of the things needed to make automobiles that the automobile companies had to do it themselves. Few companies were making wheels, batteries, or windshield wipers. Therefore, automobile makers did a lot of the manufacturing themselves. At one time, Ford Motor had its own steel company. But the economy developed and outside providers developed, such as focused factories that make steel, batteries, and windshield wipers, allowing the automobile companies to out-source a lot of the things they

had done internally because the outside providers were much better at it.

In health care there's no reason to integrate vertically because of a shortage of suppliers. The industry is blessed with a plenitude of sources of supply, and it's very hard to make vertical integration work.

Q: *So, vertical integration worked early in managed care, with Kaiser Permanente, and the Group Health Cooperative of Puget Sound, and the Harvard Pilgrim Health Plan, but it flounders later on.*

A: Yes. But I think the story there is different. Kaiser and Group Health are great organizations, and if I lived in California or in Washington State, I would belong to them. However, they're ideological organizations. They had a very strong ideology that drove them. Group Health is a cooperative. So, it has members and providers who believe in the cooperative spirit, in which providers say, 'I'll take a little bit less so you can have a little bit more.' And it's the same thing with Kaiser. They're wonderful organizations, but that kind of culture is very hard to replicate. You just can't replicate it with a cookie cutter.

In addition, vertical integration is also a problem, as one can see in Kaiser's case. When you own all the sources of supply—when you own a hospital, for example—in an era in which technology is driving people out of hospitals because of minimally invasive surgical techniques and noninvasive diagnostic and interventional radiological techniques, you're stuck with covering the costs of those hospitals. The downside to vertical integration comes when you own it all, and it's not needed anymore, you're stuck with the fixed costs of those organizations. Kaiser got hurt by a technological innovation.

Q: *Humana also failed in its efforts at vertical integration. Was that for similar reasons?*

A: The Humana example is exactly what I'm talking about. When you run an organization whose component parts have different missions, it's very hard to make that organization work. So, if you have a vertically integrated organization, and HMOs are trying to minimize medical care expenses, and hospitals and salaried physicians are trying to maximize utilization of services, it's very hard to make those two sides of the organization work together.

Q: *To play the devil's advocate for a moment, there has been much talk about vertically integrated organizations, which are usually hospital-based, and which are designed to provide seamless care across the continuum. But in your book, you say that hospitals do too many things to too many people, and they can't master competencies in all of these areas.*

A: Absolutely. Even though the focused factory is vertically integrated and it would provide an integrated system of care, it would provide it for only one chronic disease. That's infinitely more feasible than providing a 'seamless'—and I put that word in quotes—system of care. I don't think we can develop one vertically integrated, relatively convenient system that provides care for every kind of conceivable disease for every patient. It's just not realistic.

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Q: *Is horizontal integration more feasible than vertical integration?*

A: Absolutely. Health care is still a terribly fragmented industry and if you look at most other service industries, such as the hotel industry, there's a lot of horizontal integration. Most hotels are not stand-alone hotels, they're part of a chain—Marriott, Hyatt, or Hilton. Even in professional organizations there's a lot of horizontal integration. In accounting, for example, there are few independent firms. Instead, most accountants are a part of the Big Six accounting firms in which many independent accountants are partners within that large horizontally integrated structure.

Unlike vertical integration, horizontal integration is much more feasible, since it would involve chains of hospitals, of nursing homes, of focused factories, of home infusion companies, of home health companies, and so on. Ultimately, of course, we'll have longitudinally integrated chains of focused factories. Horizontal integration is feasible because it's relatively easy to replicate. Horizontal integration involves determining how to do something and then replicating it over your entire chain. So, while it's not trivial, it's not as difficult as running a vertically integrated system that involves running four to 15 different businesses simultaneously.

Horizontal integration leads to economies of scale in purchasing and economies of scale in administration. When Columbia/HCA, which is an example of the horizontally integrated hospital company, deals with its suppliers, those suppliers work hard to satisfy Columbia/HCA because it buys $2 billion worth of supplies every year.

And, when Columbia/HCA designs an information system, it designs it for more than 300 hospitals, not just one or two. There are tremendous economies of scale in designing one information system and spreading its costs over 300 hospitals.

But the real advantage of horizontal integration comes from best-practice analysis. That means you find a good way of doing something and then you replicate it in all other affiliated organizations.

Here's an example: One of the centers in a chain of 70 kidney-dialysis centers discovered a way of improving the administration of synthetic erythryopoietin, which costs a tremendous amount of money to administer. That method was then replicated in all other centers in the chain. This new way saved on the amount of the drug that needed to be administered without harming the patient.

Thus, real economies come from horizontal integration that uses best-practice analysis to develop new, more effective methods that are replicated many times over.

Q: *Is it true that another example of the same principle involves hospitals, which have acquired about 5,000 physician practices a year and they're losing $100,000 per doctor per year?*

A: Yes, for two reasons. First, because it's very hard to manage two different kinds of businesses well. A hospital and a physician's practice are two very different enterprises. Each one requires different

skills and different knowledge.

Second, most management people will tell you not to buy physician practices because you're buying the main asset of that business—the physician himself or herself—and when you buy out that person, you undercut one of the reasons that drives productivity. If a business deals with an outside vendor, most businesses prefer to make an investment in the vendor or give the vendor a long-term contract that's performance weighted. So, it's no surprise to me that hospitals are losing money on the physician practices they've acquired, although I didn't know they were losing that much—$100,000 per physician per year.

Q: *In California, many physicians and hospital executives have concluded that hospitals and large group practices are just completely different corporations.*

A: Of course, completely different. Home infusion is a different business, nursing homes are a different business, and assisted living is a different business, and so on. I don't mean to demean the health care industry, but it's just like the automobile industry or any other large manufacturing industry. You can't do everything yourself.

In my book, I have a chapter on John Deere. People say, 'What is John Deere doing in a book on health care?' Well, John Deere used to be vertically integrated, and it learned that it just can't run all those businesses as well as focused factories can. So, it kept what it does well and outsourced all the rest. It focused on what it did best. It reduced the prices of one of its major tractor lines and increased profits. The only way to reduce price and still increase profits is to increase productivity. That's what Deere did when it shed the vision that it had to do everything. It began to focus on core competence and outsourced to organizations that had competencies that Deere & Company didn't possess.

Q: *Didn't John Deere outsource a portion of its medical services to the Mayo Clinic?*

A: In fact, it in-sourced that. And that's an interesting question. Many people think that focusing on core competence means that you outsource everything. While Deere outsourced many things, it also recognized that it had some core competencies that were underutilized. One of the core competencies involved its engine division, which grew to become a multi-hundred-million-dollar division. In the process of focusing on its core competencies, the company said, 'We'll be good at making this kind of engine,' and it grew that rather than outsource it.

'Focused Factories': A Definition

In her book, *Market-Driven Health Care,* Regina Herzlinger writes that the term 'focused factory' was explained in an article in the May-June 1974 issue of the *Harvard Business Review,* "The Focused Factory," by Wickham Skinner. "A factory that focuses on a narrow product mix for a particular market niche will outperform the conventional plant, which attempts a broader mission. Because its equipment, supporting systems, and procedures can concentrate on a limited task for one set of customers, its costs … are likely to be lower than a conventional plant. But, more important, such a plant can become a competitive weapon because its entire apparatus is focused to accomplish the … task … demanded by the company's overall strategy."

In contrast, the conventional factory produces many products for many customers in a variety of markets, Skinner explained. Seeking economies of scale, it demands many tasks at once from all assets and people. Yet, in fact, the result is more likely to be numerous compromises, high overhead, and an organization unpopular with customers, Skinner wrote.

While it focused on its core competencies in the engine division, Deere also developed an unusual strategy by starting its own staff-model HMOs in rural areas. In doing so, it sharply reduced the cost of health care for its workers and dependents while increasing the quality of care delivered in these rural areas. John Deere believed it was very good at understanding the service process and the production process, and that it could deliver health care in these areas, where there are sparse medical resources.

Also, it worked with Mayo to develop disease management strategies, which at that time—four or five years ago—were almost revolutionary. Mayo applied disease management strategies in Deere's staff-model HMOs, and it was then that Deere lowered its health care cost and the enrollees got much better medical care.

Q: *In your book, you're clear that the consumer and the provider are the keys to making the system better. Are you saying that the providers that satisfy the consumer by offering the best value, convenience, and accessibility are likely to emerge as winners?*

A: Yes.

Q: *But for the right things to happen, you say the consumer must control health insurance. Are we talking about medical savings accounts (MSAs)?*

A: Not only MSAs. I am not a political figure and I'm not interested in the exact specification of so-called policy solutions. People will fight to the death about medical savings accounts versus tax credits and so on. While these are important issues, the main issue is that consumers should control the money spent on health insurance. And I think that's going to happen.

In fact, I think it's desirable that consumers control the money spent on health insurance because consumers know what they want and they'll make the cost-and-value trade-off that third parties acting on behalf of consumers, however well intentioned, cannot do. These third parties can't possibly know what each consumer wants and what he or she would decide if he or she were spending his or her own money. When people spend what they perceive to be their own money, they are amazingly cost conscious and they use that money in very effective ways. That's why it's desirable for consumers to control their own health insurance and health care expenditures.

It is inevitable that consumers will control the money spent on health insurance because managed care cannot survive due to the reasons we discussed earlier. The mandating of benefits for managed care make it impossible for managed care orga-

nizations to be cost effective.

The other option, which is a government-controlled one-payer health care system, is unacceptable as well. We know the American people won't accept it because the Clinton plan advocated regionally controlled health care systems, and that was rejected by the American people. So, if managed care is a nonoption, and if a one-payer system is unacceptable, there's only one other way to deal with health care costs and that is to let the consumer manage his or her own costs.

In the recent debate about Medicare, one of the options proposed will eventually be enacted. That proposal involved replicating the Federal Employees Health Benefit Program (FEHBP) so that it could serve Medicare beneficiaries. Essentially, FEHBP gives 2.7 million federal employees and their dependents a fixed amount of money to buy a vast array of health insurance plans. The government says, 'Here's the money, but you can't blow this money at the horse track or at Saks Fifth Avenue. You have to use this money to buy health insurance, and you pick the one you want.' That program has been so successful that premiums declined while benefits went up.

Q: *Your book has some vivid examples of the 80/20 rule, in which 80% of a plan's resources are used by 20% of the plan's enrollees. You use that rule as an argument that focused factories are feasible because they can concentrate on the 20% of the people responsible for 80% of the expenses.*

A: Yes, I use the 80/20 rule as an example. I suggest that if you are going to re-engineer the system, why not focus on the 20% of enrollees who use 80% of the resources. I also argue that doing so is entirely feasible.

Some people ask, 'How can focused factories for diabetes be feasible? After all, there are only 8 million diabetics in the United States.' Even though the American Diabetes Association recently announced that another 8 million are undiagnosed and so as many as 16 million people may have diabetes, that's a relatively small proportion of the U.S. population. But the costs of treating diabetes are in excess of $100 billion a year. If you divide $100 billion by 8 million, that gives you an average treatment cost of $12,500 per person. Therefore, designing a focused factory just for diabetes is entirely feasible. Under the 80/20 rule, that means the level of expenditure associated with a small number of people is so high that it's entirely feasible to create a system that's devoted only to their needs.

Q: *There's another example in your book. You say the Mullikin Medical Group, which was sold this year to MedPartners, asked its physicians to focus on the diseases in which the 80/20 rule was operative. As a result, the physicians focused on diabetes, on those at a high risk of a heart attack, and on neonatal care. By focusing on those three high-cost areas, they dramatically lowered costs in the system and replicated it in multiple settings.*

> **"If the PPMCs are going to make a contribution, it will be by doing best-practice analyses and replicating those best practices throughout their chains."**

A: Right. That's the virtue of horizontal integration. If the PPMCs are going to make a contribution, it will be by doing best-practice analyses and replicating those best practices throughout their chains.

Q: *Another example comes from Stanley Feld, MD, an endocrinologist in Dallas, who has a group of six physicians and they take a comprehensive approach to managing diabetes. They have reduced hospitalization and complications to the extent that their patients are hospitalized at one-sixth the rate of the general diabetic population.*

A: Those are excellent results. There's a problem with the idea, however. Some people have written to me and complained that managed care organizations don't want to contract with them because they don't want diabetic patients. And if they contract with Dr. Feld's group, and its excellence is known, a lot of diabetics might sign up with that particular managed care organization.

But I don't believe that will be a long-lasting problem for two reasons. First, when managed care organizations dominate 100% of a market, there'll be no way they can avoid seriously ill people to the extent that they may do so now. Second, what will happen is that health care systems will develop methods of risk adjustment for these people. A diabetic's average medical care costs are about $12,500 a year, for example. And when consumers receive money from their employers to seek treatment to buy their own health insurance, it doesn't make sense that my daughter, who is 24 years old, would receive the same amount of money as a 50-year-old diabetic. What will happen is that health care payers will develop effective risk-adjustment methodologies so that a diabetic gets enough money to buy the health care that she or he requires and my daughter gets enough money to buy what she requires. The Robert Wood Johnson Foundation, in Princeton, N.J., has invested a lot of money in investigating different techniques to make risk adjustment a reality.

Q: *Would you say that another example of a focused factory would be an ambulatory surgical center?*

A: It could be. A cataract center is a perfect example. An organization that does nothing but cataracts or an ambulatory surgical center that concentrates on the five or six outpatient surgeries that follow the 80/20 rule will be successful. But if it were general practice ambulatory surgery, it would lose the edge that a focused factory has.

Q: *Do you have confidence that consumers are smart enough to know to which focused factory they should go?*

A: Not every consumer is smart enough, but that's not how markets work. People think that to make a market operate well, everybody in that market has to be incredibly smart. But if that were true, we wouldn't have personal computers that are as good as they are because most people don't know anything about the guts of a personal computer. The same thing happens in the automobile market. Automobiles involve complicated technology, yet automobiles keep getting better and less expensive relative to incomes. The reason computers and automobiles get better and cheaper is that you need 16% of the people in any given market to be very smart buyers and they'll influence everybody else. That 16% is based on marketing research that's looked at many markets. ■

Individual PPMC Stocks Bear Watching

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

The prices of physician practice management company (PPMC) stocks outperformed the overall market, as measured by the S&P 500, until the spring of last year. After that, some PPMCs failed to meet Wall Street's earnings expectations, leading to a downward shift in PPMC stock valuations (see Table 1). While stock values have improved during 1997, prices remain volatile. Physicians, therefore, are advised to be diligent when evaluating the sale of a clinic in exchange for stock in a PPMC.

Given that many PPMCs have adopted a growth strategy driven largely by acquisition, versus internal growth, maintaining consistent predictable earnings growth over the long term can be difficult. To date, PPMCs have been unable to develop long-term partnerships with physician groups and to integrate and improve the operations of new practices successfully. Another obstacle for many PPMCs is that they are small, compared with Wall Street standards, and they have limited operating and management infrastructure. Combined, these factors can create much volatility in PPMC stock prices.

Despite lagging behind the S&P 500 Index in price, PPMCs still generate price-to-earnings multiples that are higher than most stocks, partly due to the faster pace at which they are expected to grow over the next five years relative to the S&P (see Tables 2 and 3). With only 5% of U.S. physicians affiliated with public PPMCs, there is much room for more integration of physicians and PPMCs.

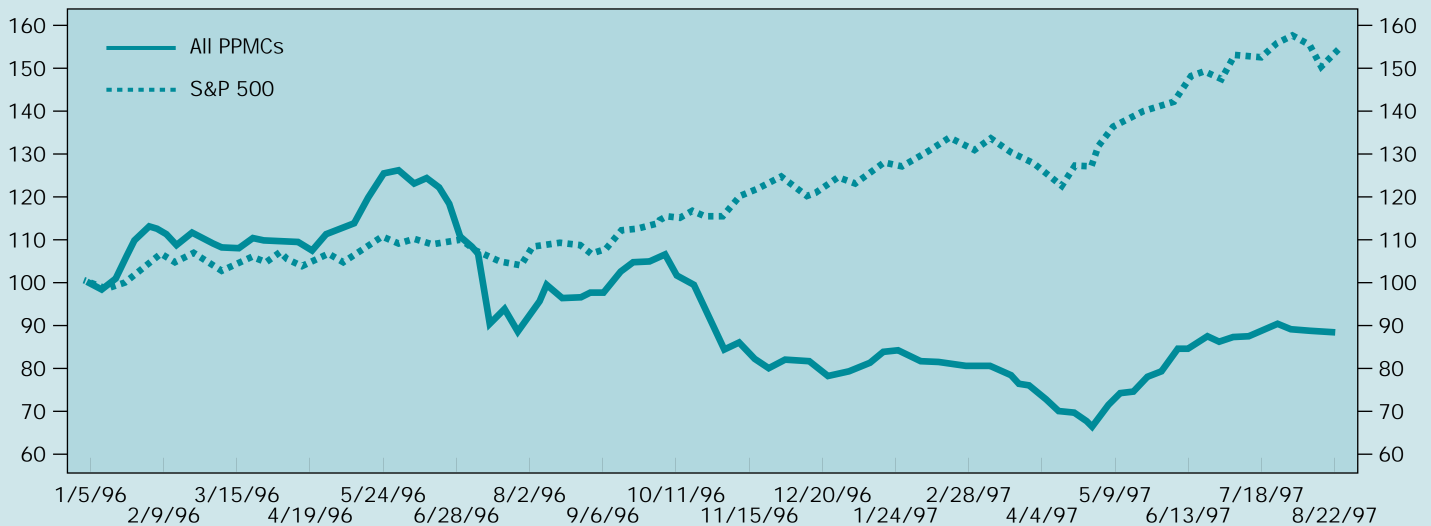
The challenge for physicians considering an affiliation with a PPMC that involves taking stock as part of the purchase price is twofold: first is to determine if the price at which the stock is being offered is fair and reasonable; second is to ascertain the likelihood that the stock will become liquid in the future via an initial public offering or a sale of the company. SEC regulations typically require physicians to hold an acquiring PPMC's stock at least one year before selling, meaning physicians would be unable to divest the stock if the stock price declined in that one-year period.

When considering an affiliation with a PPMC that involves stock as part of the deal, physicians should look for:

- A long and stable operating history,
- An experienced management team and board of directors,
- Access to capital,
- Disciplined growth and acquisition strategy,
- Compatible culture and vision, and
- The ability to add value to the physician group through physician recruitment and acquisitions, managed care contracting, or operating efficiencies.

Whether a PPMC possesses these characteristics can be determined through due diligence on the part of physicians. By interviewing management, meeting with physicians who have affiliated with the PPMC previously, reading business plans, analyzing financial information, and assessing operational infrastructure, physicians will be better prepared to evaluate the merits of an affiliation with a PPMC. ■

Table 1: PPMC Indices Weekly from Jan. 5, 1996, to Aug. 22, 1997



PPMC Index Includes:
Multispecialty PPMCs: MedPartners, PhyCor, Complete Management, Medical Asset Management, and FPA Medical Management.
Single-specialty PPMCs: Physician Reliance Network, MedCab, Response Oncology, OccuSystems, Physicians Resource Group, Orthodontic Centers, EquiMed, Omega Health, and American Oncology Resources.
Hospital-based PPMCs: Costal Physician Group, Pediatrix, Sheridan Healthcare, and EMCare Holdings.

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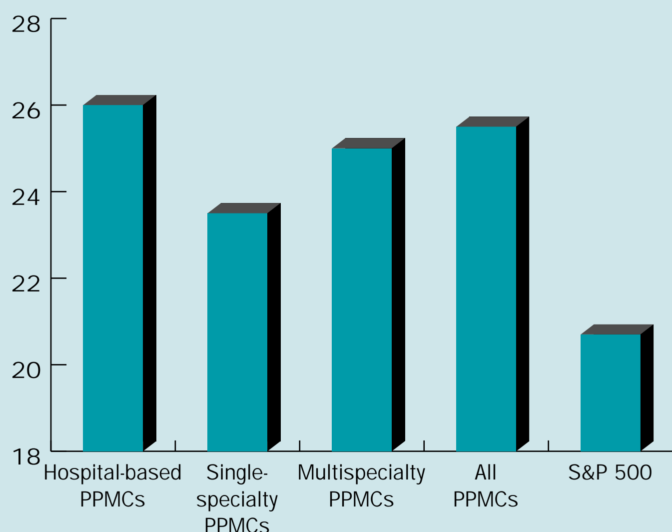
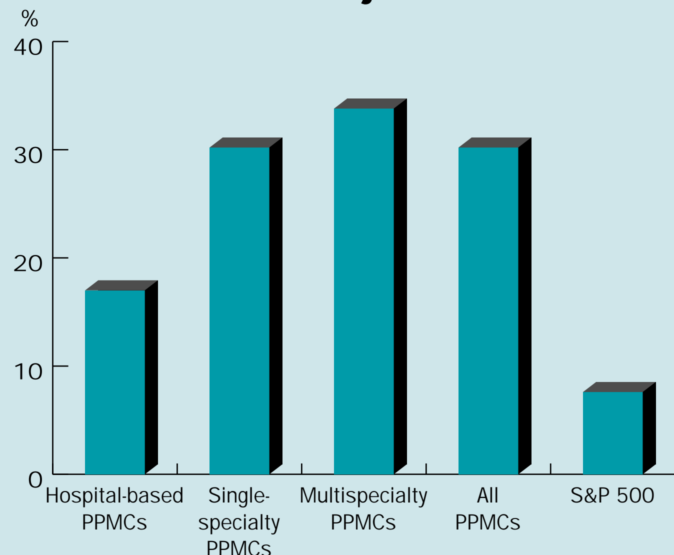
Table 2: Price-to-1997 Estimated Earnings



Source: IBES International. Inc., New York

Table 3: Five-Year Projected Growth Rate



Source: Zacks Investment Research, New York.

Table 4: Stock Monitor

Company - Ticker	Price 08/22/97	% Change Since 01/02/96	1997E P/E
	$	%	x
Princeton Dental Management Co. - PDCCD	3.13	194.1	NA
FPA Medical Management.- FPAM	26.25	183.8	29.5
Coast Dental Services Inc. - CDEN (1)	22.25	178.1	NM
Integrated Orthopaedics - IOI	6.25	78.6	NA
Dental Services of America - FLOS (2)	0.84	72.2	NA
Complete Management Inc. - CMI	14.88	68.8	16.7
American Healthchoice Inc. - AHIC	5.13	64.0	NA
EmCare Holdings - EMCR	37.81	62.6	25.0
Gentle Dental Service Corp. - GNTL (3)	8.01	60.1	NM
Omega Health Systems Inc. - OHSI	8.38	59.5	33.5
Advanced Health Corp. - ADVH (4)	20.50	57.7	NM
Apple Orthdontix Inc. - AOI (5)	11.00	57.1	NM
Pediatrix Medical Group - PDX	43.06	55.2	32.9
Orthodonic Centers of America - OCAI	17.38	52.7	34.8
Talbert Medical Management Holdings Corp. - TMMC (6)	62.31	51.1	NM
Monarch Dental Corp. - MDDS (7)	19.31	48.6	NM
Specialty Care Network Inc. - SCNI (8)	11.38	42.2	29.9
OccuSystems Inc. - OSYS	27.88	40.3	34.4
Sheridan Healthcare - SHCR	11.00	4.8	17.7

Company - Ticker	Price 08/22/97	% Change Since 01/02/96	1997E P/E
	$	%	x
Physicians' Specialty Corp. - ENTS (9)	8.25	3.1	21.2
EquiMed Inc. - EQMDD	21.63	3.0	NM
MedCath Inc. - MCTH	18.56	-7.2	28.6
PhyCor Inc. - PHYC	28.38	-9.9	33.8
Medical Asset Management Inc. - MAMT	1.97	-10.0	6.0
PhyMatrix Corp. - PHMX (10)	12.81	-14.6	18.0
SunStar Healthcare Inc. - SUNS (11)	4.13	-17.5	NM
ProMedCo Management Co. - PMCO (12)	7.25	-19.4	18.1
Metropolitan Health Networks Inc. - MDPA (13)	4.44	-26.0	NA
The Company Doctor - CDOC (14)	3.69	-29.8	NA
UCI Medical Affiliates Inc. - UCIA	2.63	-36.4	NA
MedPartners Inc. - MDM	20.31	-36.5	18.0
Response Oncology Inc. - ROIX	7.69	-38.5	NA
American Oncology - AORI	14.63	-40.0	30.5
Dentlcare Management Inc. - DCMI	0.75	-40.0	NA
Physician Reliance Network - PHYN	9.56	-52.8	20.8
Physicians Resource Group - PRG	8.19	-56.9	12.0
Integrated Medical Resources Inc. - IMRI (15)	1.88	-68.8	NM
Allegiant Physician Services - ALPS	0.24	-72.3	NA
Coastal Physician Group - DR	1.75	-87.3	8.8

Footnotes:
(1) IPO date was 2/11/97.
(2) Changed name from Campbell Capital Corp. and began trading under FLOS ticker 7/24/96.
(3) IPO date was 2/13/97.
(4) IPO date was 10/3/96.
(5) IPO date was 5/23/97.
(6) Formerly part of FHP International Corp., which merged with PacifiCare Health Sys. 2/18/97. Talbert spun off eff. 4/25/97.
(7) IPO date was 7/18/97.
(8) IPO date was 2/5/97.
(9) IPO date was 3/21/97.
(10) IPO date was 1/24/96.
(11) IPO date was 5/16/96.
(12) IPO date was 3/12/97.
(13) IPO date was 2/20/97.
(14) IPO date was 2/7/96.
(15) IPO date was 11/6/96.

MedPartners Wants to Buy 9 Clinics in Massachusetts

Blue Cross and Blue Shield of Massachusetts is negotiating exclusively with MedPartners Inc. of Birmingham, Ala., to sell nine medical clinics, shutting out Physician Quality Care, a physician practice management company (PPMC) in Waltham, Mass., *The Boston Globe* reported. In August, MedPartners had written to the 120 physicians who practice at the clinics and promised them a pool of $10 million to be paid as a signing bonus. The clinics employ 900 full-time workers, including the 120 physicians.

Interestingly, Blue Cross decided in August to deal exclusively with Physician Quality Care despite the $10 million bonus offer by MedPartners. But that pact expired last month without a sale, according to Blue Cross, which declined to say why the talks collapsed. MedPartners may simply have deeper pockets than Physician Quality Care and could easily have bid more than the $50 million Physician Quality reportedly offered, said the *Globe*. MedPartners, which declined to comment, has more than 13,000 physicians in 39 states and more than $6 billion in annual revenues, the *Globe* said.

Comment: *Blue Cross's health centers are desirable for any company, especially PPMCs seeking to contract directly with insurers and managed care organizations. PPMCs have a minor presence in the Massachusetts market, which is dominated by staff-model health plans.*

More Providers Seek to Focus on Customer Service

Many hospitals and physicians seeking to win managed care patients are adopting a new attitude: Be customer-friendly, according to the *Pittsburgh Business Times*.

Patients scheduled for surgery at Sewickley Valley Hospital, in Sewickley Pa., two years ago waited an average of 76 minutes past the scheduled surgery time. By adopting best practices, the hospital cut the average surgical delay to 25 minutes. It did so with the help of the Institute for Healthcare Improvement, an organization in Boston that helps provider organizations adopt best practices.

Linda Hummel, perioperative manager at the hospital, said the process began by focusing on one operating room with one surgeon and one surgical team. Once delays were cut in that group, the concept was expanded to other operating rooms.

Marilyn Rudolph, a former nurse manager of outpatient surgery and gastrointestinal lab departments at Sewickley Valley, was involved in the project and has since been hired by VHA Inc., in Dallas, as the national hospital consortium's director of performance innovation collaboratives. Rudolph designs and offers similar improvement programs for VHA hospitals nationwide. "Hospitals don't have years anymore to make improvements," Rudolph told the newspaper.

Tri Rivers Surgical Associates, a group of surgical specialists in McCandless, Pa., also is focusing on being more patient-friendly, the newspaper said. "Customer service issues are critical not just in the success but in the survival of a surgical subspecialty," said D. Kelly Agnew, MD, an orthopedic surgeon at Tri Rivers. Primary care physicians who make referrals, for example, get a written report on the patient within 24 hours. To help patients avoid costly emergency room visits, Tri Rivers runs a fracture clinic on Saturdays to which primary care physicians can send patients.

Comment: *Tri Rivers is trying to eliminate an air of arrogance that has been present among some subspecialists, Agnew said. Although the efforts have increased practice overhead, Agnew said, they are necessary. "From a service standpoint, if you don't take that step, what's at stake is the survival of the practice," he told the newspaper.*

Managed Care Offers More Choice and Higher Cost, According to Two Studies

Consumers are seeking access to more physicians by joining health plans offering a wide choice of specialists. Point-of-service (POS) plans and open-access plans, which allow patients greater choice, are growing at four to eight times the rate of HMOs that restrict access to physicians more closely, according to a report by The Advisory Board Co., a consulting firm in Washington, D.C. This growth is possible even though these plans cost enrollees more than plans that control access more tightly.

A survey earlier this year by KPMG Peat Marwick, health care consultants in Montvale, N.J., shows that 48% of workers are now enrolled in POS plans or PPOs, which offer a choice of physicians, up from 41% last year. The proportion of enrollees in traditional restrictive HMOs remained at 33%. The Peat Marwick survey showed enrollment in fee-for-service (FFS) plans declined while managed care enrollment grew steadily since 1988 (see table). Note that POS plans did not exist in 1988.

Fee-for-Service Enrollment Declines (%)

Year	FFS	HMO	PPO	POS
1988	71	18	11	N/A
1991	42	26	22	10
1994	35	25	25	15
1996	26	33	25	16
1997	18	33	31	17

Source: KPMG Peat Marwick, Montvale, N.J.

Comment: *Allowing more patients to by-pass primary care gatekeepers and go directly to capitated specialists comes at a price: higher premiums, higher co-payments, and higher payments for specialty care, according to* The New York Times. *Yet, employees are willing to pay for the right to choose their physicians, hospitals, and other services, the* Times *said.*

NEWS AND COMMENTARY

Home Care Providers Come Under Scrutiny

The Clinton administration wants to eliminate unscrupulous home care providers and will not certify new ones to participate in the Medicare program while it conducts a probe aimed at eliminating fraud and abuse.

The federal Health Care Financing Administration (HCFA), which runs Medicare, also will require home health agencies to re-enroll periodically. Re-enrollment will make it easier for HCFA to expel unwanted providers and to determine if all providers can meet new tougher standards for inclusion in the program. Also, HCFA plans to double—to 1,800 from 900—the number of home health agency audits it does annually, *The Wall Street Journal* said.

Comment: *HCFA fostered the growth of home care by seeking ways to treat patients in lower-cost settings outside of hospitals. This year, HCFA will spend $18 billion on home care, up from $2.7 billion in 1989.*

Alternative Medicine Appeals to Mainstream

Alternative medicine may no longer be just a niche market, since Americans spend $14 billion a year on alternative treatments.

Alternative medicine's most famous proponent is Andrew Weil, MD, an author and Harvard Medical School graduate. His sixth book, *Spontaneous Healing,* has been on the paperback best-seller list for over a year. Weil's latest book, *Eight Weeks to Optimum Health,* his seventh, is a hard-cover best seller. His Web site, "Ask Dr. Weil," is visited more than 83,000 times a day, according to *The New York Times.*

Comment: *Skeptics remain, of course. Arnold Relman, MD, former editor of* The New England Journal of Medicine, *says, "The great majority of physicians oppose Weil because they worry about a world in which claims and hopes become facts. I say, 'Until, you get some evidence, have the decency to be more restrained.'"*

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