Many medical groups are changing their compensation plans to stress collective performance. Managed care’s emphasis on prepaid reimbursement, as opposed to traditional fee-for-service, is driving this change. Physicians are learning to think about their group’s goals, to look for cost-saving protocols, and to align their personal ambitions with the needs of other group members.

As the number of patients enrolled in managed care plans rises, many physicians are accepting compensation arrangements based as much on group performance and profit-sharing as on salaries. Under fee-for-service plans, physicians in medical groups are paid for the work they do; and the more patients they see, the more income they receive.

“It’s a new world,” says James Nuckolls, MD, CEO of Carilion Healthcare Corp., in Roanoke, Va., a medical group of about 170 primary care physicians who practice individually or in small groups. “Physicians who were used to being paid for piecework now have to learn how to think in terms of controlling health care costs as a group. That is creating tension among physicians.”

— James Nuckolls, MD, Carilion Healthcare Corp.
New Column Debuts on Legal Issues

Starting with this issue, the American Medical Association’s Health Law Division will contribute a regular column to Physician Practice Options. In addition, Edward B. Hirshfeld, JD, vice president of the AMA’s Health Law Division, joins our Advisory Board.

We are adding this column on legal issues because legal topics have taken on new importance—particularly those relating to physicians’ organizational options—as managed care has grown to become the predominant form of reimbursement in many markets. This trend continues, and the legal ramifications become more complex, we believe it is time to add regular coverage from a highly knowledgeable source.

In this month’s newsletter, Hirshfeld opens with a thorough discussion of the issues involving market share concentrations that would trigger an antitrust action when physicians are forming a group or merging one group with another. (See “Antitrust Rules Govern Group Practice, Network Formation,” page 12.)

In the coming months, we plan to cover other antitrust issues, physician-hospital relationships, provider-sponsored organizations, and the so-called Stark laws, which govern physician referrals to facilities they own. In particular, we plan to address the following questions:

• What is the status of the movement to make it easier for doctors to band together?
• What legal issues are involved when physicians go into business with hospitals?
• Is there a limit to how much a physician can be paid to serve on a hospital committee or to serve as chief of a hospital department?
• What are the rules in physician-hospital joint ventures regarding ancillary revenue?
• When forming a provider-sponsored organization (PSO), is it necessary to split startup costs 50-50?
• Can physicians own a PSO without hospital participation?
• Are there restrictions on who the financial capital partners of a PSO can be?
• What advantages under the Stark laws, if any, do physician groups have over solo practitioners when referring patients?
• What rules apply to physicians regarding risk-sharing provisions and federal anti-kickback regulations?

Our mission is to provide practical information to help physicians evaluate their organizational options under managed health care. Toward that end, we focus our articles on areas that significantly affect physicians’ practice environment, including:

• Managed care expertise;
• Capital—access, sources, and strategies;
• Data collection and outcomes management;
• Practice management and marketing;
• Physician group formation and network affiliation;
• Health care law and regulations.

As always, we invite readers who have questions about these issues to call us toll-free at 888/457-8800. We have extensive resources at our disposal and will either answer your questions or refer you to an expert who can.

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Subscription Price: $220 per year, 12 Issues
Issue Price: $25 each
COMMENTARY

West Coast Patient Satisfaction Survey Reports on Physician Performance

A recent survey of patients is one of the first published polls to focus on the performance of physician groups not health plans. The survey of patients focused on 58 physician groups in California, Oregon, and Washington state. The survey is another step in the evolution among the many imperfect systems designed to measure health care quality.

Health care purchasers are developing these systems because they want to provide consumers with useful information that will help them to choose among physicians and health plans and because they are concerned that their focus on cost control has caused quality to deteriorate. “In the past, most satisfaction surveys looked at member satisfaction with their health plan,” says Walter J. Unger, principal of Walter J. Unger & Associates, health care consultants in Laguna Niguel, Calif. “While that’s been helpful, satisfaction with physician performance is where the rubber meets the road.”

Titled the Physician Value Check Survey, the poll was done by the Pacific Business Group on Health (PBGH) and The Medical Quality Commission (TMQC). PBGH is a coalition of 33 California employers in San Francisco that buy health care services by contracting directly with providers. TMQC is a nonprofit organization in Seal Beach, Calif., that accredits medical groups. “PBGH and TMQC have taken the whole process to a new level,” comments Unger.

Consumer Preferences

Consumers prefer having information on satisfaction at the physician-group level over information on health plan satisfaction, explains TMQC’s Lori Bloomfield. Patients choose their doctor first and then choose a health plan, she says. “In focus groups conducted by PBGH, consumers expressed a desire to see performance information at the physician-group level,” she comments. “The study has opened up a new avenue of communication between physician groups and patients, and participating groups are being urged to view the study as an opportunity and a catalyst for improvement.” PBGH and TMQC will repeat the survey in 1998.

PBGH and TMQC divided results geographically and provided information on specific medical groups. Among the patients surveyed in Northern California, the average overall patient satisfaction rating among 22 medical groups was 80% (out of 100); the average overall quality of care was 67%; physician communication skills was 66%; and physicians’ help in keeping cholesterol under control was 46%. In Southern California, overall satisfaction among 27 medical groups was 78%, and most other scores were slightly lower than the corresponding scores from Northern California.

PBGH Executive Director Patricia Powers explained that the lower scores in Southern California may reflect the fact that the area is widely regarded as more competitive than the Northern California market. “The survey results raise the question, ‘Are we pushing too hard?’ on competition or is it a relatively high level of dissatisfaction to be expected in the midst of significant changes in the health system?” Powers told The Wall Street Journal.

To reach the largest number of consumers possible, PBGH and TMQC have posted the survey results on the World Wide Web, says Cheryl Damberg, director of quality for PBGH. “That’s the purpose of the survey, to provide as much information to as many people as possible,” she says. The PBGH address is www.healthscope.org and TMQC’s address is www.tmqc.org.

The intent behind reporting the results to consumers and health care purchasers is to intensify physician awareness of the importance of quality, says Bloomfield. “The goal is to develop a marketplace in which all participants are better informed on the subject of quality and can use this new information as a navigational aid to reach higher levels of quality,” she explains.

Also, PBGH asked a panel of clinicians and researchers to recommend specific initiatives that the profiled groups could undertake to improve quality, Bloomfield says. “Their responses spanned the gamut of health-related interventions,” she explains. “Some focused on improving the processes of traditional medical care, while many targeted behaviors, such as reducing smoking, increasing exercise, and improving patient self-management of chronic diseases.”

Based on the findings, PBGH and TMQC have made the following recommendations to medical groups:

• Be more aggressive about monitoring and managing enrollee health risks between physician visits;
• Make better use of paraprofessionals and information technology;
• Adhere more strictly to established treatment protocols; and
• Refocus ambulatory care professionals from diagnosing and prescribing care to developing programs aimed at preventing illness and fostering self-help among patients.

(Continued on page 4)
T he Importance of Quality

The effort by PBGH and TMQC to survey patients about physicians is significant, although opinions differ as to whether the survey accurately reflects the quality of health care. To date, quality has been measured at the health plan level by such organizations as the National Committee for Quality Assurance in Washington, D.C., which has accredited some 330 of the nation’s 600 HMOs and collected extensive data on performance from 90% of health plans through the Health Plan Employer Data and Information Set (HEDIS). The problem with accreditation and using HEDIS data is that these tools provide little evidence of clinical results or of the performance of individual physicians and medical groups.

“It never made a lot of sense to measure data at the plan level,” says Thomas Mayer, M.D., a health care consultant in Huntington Beach, Calif. “The decision to survey at the physician level, the level at which people actually receive care, is a good one. This kind of information allows consumers to make better choices in picking physicians.”

Mayer asks, however, whether the survey provides accurate data about the quality of care being delivered. “The issue is whether such surveys actually measure quality of care, and if the data are self-reported, how objective they are,” he explains. “If the survey is subjective, it may be difficult to standardize comparisons because what can consumers actually say about the quality of health care? Patients measure quality based on whether their expectations are met. If a patient is angry about the treatment he has received, in his mind, he’s received poor quality care. Quality should be measured on clinical outcomes, and it is very hard to measure the true quality of care through patient perceptions. But you can, and should, measure the quality of service.”

An additional problem with medical group-level quality surveys is that they are difficult to conduct, says Unger. “Medical groups are far more numerous than health plans,” Unger says. “Although PBGH and TMQC wisely took the step of identifying the doctors and medical groups in their patient survey forms, this isn’t always the case. Patients do not know the names of the physicians they see, but they often don’t know the name of the medical group the physician belongs to, especially when the referral has been made by a health plan.” The PBGH and TMQC survey was done in California, Oregon, and Washington state, where a large concentration of large medical groups makes doing such a survey more feasible than it would be to do a similar survey in other parts of the country, Unger says.

In any case, such surveys can be useful to the profiled physicians. “The surveyed physicians can use this information,” Unger says. “Some may have a knee-jerk negative reaction, being defensive about the type of data that was collected, but many will use the information as a tool for determining how well they are meeting patient expectations. The more information we have about what we do, the better we can perform.”

Both consumers and purchasers are demanding such information, says Brooks G. O’Neil, managing director and health care industry analyst with Piper Jaffray Inc., an investment firm in Minneapolis. “The day is coming, and coming soon, when people will not ask their neighbor what doctor they should see, but instead will demand data on physician performance before making a choice,” O’Neil says.

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The Physician Value Check Survey Methodology

F or the Physician Value Check Survey, the Pacific Business Group on Health (PBGH), in San Francisco, and The Medical Quality Commission (TMQC), in Seal Beach, Calif., surveyed 1,000 patients enrolled in managed care plans. The patients were being treated by one of 58 medical groups in California, Oregon, and Washington state. Surveys also were sent to 4,000 patients enrolled in PPOs in Northern and Southern California. All patients were ages 18 to 70 and had seen a physician at least once since 1995.

Questions were taken from survey instruments published in several national accreditation and quality measurement programs, including the National Committee for Quality Assurance and the American Association of Health Plans, both in Washington, D.C.

PBGH and TMQC sent more surveys to individuals aged 50 to 70 than to younger individuals in California, Oregon, and Washington state, where a large concentration of large medical groups makes doing such a survey more feasible than it would be to do a similar survey in other parts of the country. Unger says.

Approximately 10 days before the survey was mailed, PBGH and TMQC sent the patients a postcard announcing the survey. The postcard was designed to alert the survey participants and to identify nondeliverable addresses. To improve the likelihood of response, a cover letter was printed on the letterhead of the patient's physician group and signed by the group’s medical director.

Two weeks later, a reminder postcard was mailed to patients asking them to complete the survey or call for another copy. Approximately four weeks after the initial mailing, all patients who did not respond were sent a replacement questionnaire. Six weeks after the initial survey was mailed, PBGH and TMQC made telephone calls to all those who had not responded.

The survey covered four areas:

1. Patient experience and satisfaction with care provided by physicians;
2. Satisfaction with selected preventive care services;
3. Satisfaction with care received for high blood pressure and high cholesterol; and

Satisfaction issues included access to care (such as office hours and accessibility of physicians after hours); promptness of care (such as length of time waiting to see a physician); cost of care (such as amount paid out-of-pocket); technical quality (such as thoroughness of treatment and amount of time a physician spent with the patient); communication (such as whether procedures and the use of medications were explained adequately); courtesy of staff; and overall satisfaction with physicians.
“A meaningful compensation package does not produce shot-gun medicine; that’s what costs money. Careful medicine tied to a team approach is the most effective medicine.”
— Bruce Haga, West Florida Medical Center Clinic

“Managed care is coming,” he says, “and we want to be ready.” Carilion recently hired health care consultant Ceqka & Co., of Atlanta, to help redesign its compensation program and intends to implement a new plan in October 1998.

“You can tell more about where a group is heading through its compensation plan than through its strategic plan,” says Randy Gott, a Ceqka vice president and a consultant to Carilion. “A compensation plan offers insight into organizational values in terms of physician behavior. How a group measures performance can determine how well it will survive in today’s managed care market.”

In designing a new compensation program, Carilion’s goal is to encourage its member groups to work together to practice cost-effective medicine. Doing so should improve the overall quality of care. “We want to build up the group concept,” Nuckolls explains. “We’ll say to doctors, ‘If your practice does well, you’ll be paid a little more, and if your region does well, you do even better. It’s up to you to make that work.’ We believe that concept, of an overall group and regional effort, will improve patient accessibility and cost-effective ancillary services.”

By aligning incentives of individual physicians and their groups, a physician organization can produce better medicine, says Bruce Haga, CFO of the West Florida Medical Center Clinic, a multispecialty group of 150 physicians in Pensacola, Fla. “Long-term costs can far exceed short-term savings if doctors don’t practice effective medicine,” he says. “A meaningful compensation package does not produce shot-gun medicine; that’s what costs money. Careful medicine tied to a team approach is the most effective medicine.”

Medical groups usually compensate physicians with salaries tied to productivity levels. Physicians are expected to treat a certain number of patients within a specified time. If they meet productivity targets, they receive their full salary. If they fail to meet their targets, their compensation may be reduced; if they exceed expectations, they may receive bonuses.

A New Dynamic
Since managed care accounts for a large and increasing amount of group revenue, it encourages new incentives to reduce the emphasis on traditional productivity levels to determine compensation. Managed care payers stress cost containment and often compensate medical groups through prepaid monthly reimbursements. Medical groups operating under capitation or other forms of prepaid man-
Determining Compensation: A Typical Plan

Physician compensation plans in medical groups are usually based on both salaries and bonus incentives tied to productivity. By emphasizing profit-sharing and promoting preventive care, managed care plans are changing the way many physicians are paid. Even so, most medical groups follow a basic compensation plan with several key elements, including base salary determination criteria, productivity expectations, and incentive programs. The following is a typical plan of Findley Davies Inc., health care consultants in Toledo, Ohio.

Base Salary
To determine base salaries for physicians in a medical group, Findley Davies recommends physician managers follow five specific steps:

1. Determine base salary ranges through regional comparative market surveys, usually conducted by consultants, such as the Medical Group Management Association in Denver.
2. Determine group midpoint salary rates, which are often the median salary ranges determined by the surveys. To limit discord among physicians, avoid extreme salary ranges by ensuring that no base salary exceeds other salaries within a specialty by more than 55%.
3. Relate the base salary for individual physicians to post-residency experience, board eligibility, and board certification.
4. Adjust base salaries up or down annually, according to productivity levels and group profits. In doing so, be sure that any adjustments are based on specific and clearly defined criteria.
5. Adjust base salaries for physicians who do or do not perform certain specified activities, such as receiving telephone calls from patients after hours or following guidelines for preventive programs or clinical case management. To ensure overall productivity and to protect morale, compensation should not be reduced below 10% of base salary for physicians who do not perform these tasks.

Productivity Expectations
Managed care emphasizes controlling overall utilization. Even so, individual productivity is the primary basis for determining group practice budgets and for establishing financial incentives. Base salaries are usually related to productivity expectations, and those expectations should be readily achievable and based on the size of the patient population.

When productivity levels are not met, group administrators and the medical director should review performance with individual physicians (see Table 1). If a physician’s productivity remains below expectations for two consecutive quarters, adjust his or her base salary for the next two quarters and discuss with the physician the effect individual productivity has on the group’s budget.

Productivity levels are used to determine annual budgets for medical groups, and budget levels can be used to determine incentive programs. Productivity levels are adjusted for peak seasonal periods and should be related to practice settings, such as urban or rural environments. The time required to meet targeted productivity levels depends on patient mix, a severity of illness index, the experience and efficiency of physician members and staff, and the capacity of the staff to accept new and walk-in patients (see Table 2).

Incentive Program Design
Incentive pools are blocks of money set aside to be paid as bonuses. These blocks generally equal 25% of an established median salary for a physician. If profit expectations are met or exceeded, the full amount in the incentive pool could be paid. If not, the pool can be reduced, usually by about one third. So, in an incentive pool that is 25% of an established median salary, the total amount available would be reduced to 16% of the median salary.

Usually, three factors determine how incentives are weighted and paid to individual physicians:

- Individual productivity,
- Group-based quality indicators and patient satisfaction, and
- Group expectations.

Groups with a large number of managed care contracts place strong emphasis on patient satisfaction and group expectations.

Individual productivity. Each physician should be given specific productivity goals when the budget is prepared. To be eligible for any productivity incentive, physicians are usually required to meet at least 90% of their goals each quarter. Levels of productivity can be set above the 90% cutoff, and a proportion of incentives can be paid based on those levels. If, for example, only 90% of productivity is met, a physician could receive 50% of the bonus payments made to physicians who meet 100% of productivity levels set for that specialty. If 105% of productivity levels are met, the physicians could receive 130% of the standard bonus payment.

Quality and patient satisfaction. Quality factors should be based on predetermined and specific criteria, such as the results of patient satisfaction surveys, audits of medical charts to reflect treatment practices, and continuing education. Incentive payments can reflect these quality measures.

Group expectations. Group expectations can include such contributions to the medical group as work attendance and punctuality, meeting attendance and participation, and professional presentations. A physician’s performance in these areas can be evaluated by administrators, including the medical director.
aged care in which they receive a per member per month fee may be at financial risk for the cost of delivering care to these patients. Many medical groups, therefore, tie physician compensation and bonuses to how well the group performs.

A group can do so by increasing its emphasis on individual performance evaluations and overall group productivity, rather than on individual productivity, Nuckolls says. “The goal is to align individual incentives with group incentives,” he says. “Physicians traditionally are highly individualistic. It requires a major educational effort to change how they see their performance in relation to the performance of the overall group.”

Haga’s West Florida Medical Center Clinic also emphasizes the team approach. To do so requires educating physicians, he explains. “One way to do that is through profit-sharing,” Haga says. “For doctors, the most effective incentive is compensation. But incentives should be tied to departmental performance, not just individual performance. Education is important in that process.”

When physicians are educated about how managed care works, they can make informed decisions about the kinds of tests they order and the number of referrals they make, says Cejka’s Gott. “I’m not talking about less care, but better care. We want to provide information that can be used to measure the quality of care being delivered, such as patient satisfaction surveys, hospital referrals, and compliance with formularies.”

Essentially, medical groups making compensation distribution decisions are determining how to deal with a declining medical dollar, says Steven M. Berkowitz, MD, national practice leader for physicians services for Hay Management Consultants in Dallas. “Physicians do not want to see their incomes decline— and overall, physicians’ incomes are not declining. But if that is to continue, they must learn how to distribute group revenue in ways that save money. They must learn to reduce overhead and practice treatment protocols that can enhance the compensation share of their group income.”

But such protocols must involve more than productivity levels, says Berkowitz. They should require physicians to adjust referral patterns; deliver ancillary services, such as prevention programs and blood tests; and be willing to be involved in quality-related issues, such as outcomes measurements, he says. In other words, protocols should require physicians to be involved in reaching standards of care that produce excellent results in a cost-effective manner. “To do so requires a commitment to the group as a whole,” Berkowitz explains.

Aligning incentives so that all physicians recognize common goals is critical to a fair and individually advantageous distribution of group revenue, says Carson Dye, a director with Findley Davies Inc., health care consultants in Toledo, Ohio. “To achieve that, physicians should be treated as partners in a group, never as employees. They must be involved in compensation arrangements and in setting group policy and governance.”

Multispecialty Groups

Of all groups facing compensation issues, multispecialty groups face the most vexing issues, says Walter J. Unger, principal of Walter J. Unger & Associates, health care consultants in Laguna Niguel, Calif. “Managed care emphasizes primary care services and often discourages the use of specialty services, placing specialists further down the food chain in multispecialty groups,” Unger says. “Some specialists have been experiencing a declining rate of referrals and income as managed care’s influence on the health care market has grown.”

Compensation arrangements in multispecialty groups are difficult to manage chiefly because specialists receive most of their income from single, expensive procedures,

<table>
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<th>Table 1: Typical Productivity Standards</th>
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<td>Group</td>
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<tr>
<td>Internal medicine</td>
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<tr>
<td>Pediatrics</td>
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<td>Occupational medicine</td>
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Source: Findley Davies Inc., Toledo, Ohio, 1996.

<table>
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<th>Table 2: Targeted Productivity Levels</th>
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<tbody>
<tr>
<td>Practice setting</td>
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<td>New resident</td>
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<tr>
<td>Established patient base</td>
</tr>
<tr>
<td>Experienced physician</td>
</tr>
<tr>
<td>Established patient base</td>
</tr>
<tr>
<td>Acquired patient base</td>
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Source: Findley Davies Inc., Toledo, Ohio, 1996.
Physician Salaries Rise, According to One Survey

Dozens of organizations conduct surveys on physician compensation, and many have shown physician salaries rising, regardless of compensation arrangements and despite the growing influence of managed care.

One such survey is the AMA’s Socioeconomic Monitoring System, which conducts annual surveys of physician income. It shows the average income for self-employed physicians rose to $230,800 from $210,200, a 9.8% increase between 1994 and 1995, the most recent period for which survey data are available. Overall, income for physicians grew 7.2% in that period, to $195,500 from $182,400. For specialists, the largest single increase in average income was among ob-gyns, whose income grew to $244,300 from $200,400, an increase of 21.9% between 1994 and 1995. However, the average income for physicians who work as independent contractors, a category that includes most physicians in staff-model HMOs, fell 7.7% during that period to $155,500 from $168,500.

Another survey shows that medical groups are becoming increasingly dependent on managed care for revenue. In a survey last year by the American Medical Group Association (AMGA), in Alexandria, Va., managed care represented the fastest-growing source of revenue for group practices, but fee-for-service still accounts for more total income.

Managed care’s share of total revenue paid to physicians in 1995 rose to 31%, up from 27% in 1994. The fee-for-service share of compensation fell to 44% from 45% in the same period. The amount of group income from Medicare fell to 25% from 27% between 1994 and 1995, according to the AMGA.

Physician Net Income After Expenses and Before Taxes
Results of surveys conducted in 1995 and 1996 of nonfederal physicians providing patient care ($ in thousands)

<table>
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<tr>
<th>Category</th>
<th>1994 mean ($)</th>
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<th>Percentage change (%)</th>
<th>1994 median ($)</th>
<th>1995 median ($)</th>
<th>Percentage change (%)</th>
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<th>Percentage change (%)</th>
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<td>West</td>
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Source: Socioeconomic Monitoring System, AMA, Chicago, 1996.

(Continued from page 7)

Unger says. Moreover, specialists receive a large percentage of their income from Medicare, and Medicare reimbursement rates are falling.

“There is often a tremendous diversity in the perceived value of production. The most common unit of service for primary care physicians is office visits, which are comparatively predictable, inexpensive, and frequent. Specialists receive most of their income from expensive and relatively infrequent procedures. Thus, a cardiologist may generate twice the fee income as a PCP. The income disparity causes complicated and often controversial compensation schedules. The difference in productivity standards between PCPs and specialists in multispecialty groups usually leads to nearly endless debate,” Unger says. “As a result, compensation packages may change annually.”

“To achieve equitable compensation plans, physicians should be treated as partners in a group, never as employees. They must be involved in compensation arrangements and in setting group policy and governance.”

— Carson Dye, Findley Davies Inc.
Dr. Dickey, in your family practice residency at Texas A&M University, what advice do you give the young men and women in that program and what do they ask of you?

A: Since they are focusing so closely on clinical medicine, I'm usually the one who has to bring up policy and AMA-type issues. I try to use the education time not only to give them a strong clinical base, but also to share with them what I think the foundation of medicine is: practicing high-quality medicine with the highest of ethical standards, and putting the patient first. If they do that, they'll succeed financially and the personal rewards will be there as well.

Q: What do you think of the trend of consolidating physicians through physician practice management companies?

A: Before physicians join an organization they have to ask what the purpose of that organization is: Is its goal to free up a physician's time so that more time can be spent caring for patients? Is its goal to show physicians how to increase the bottom line without improving the quality of care, physicians need to look at that organization carefully, perhaps even with a somewhat jaundiced eye.

In a market-driven system, buyers insist that physicians create clinical guidelines and set criteria for improving quality and measuring outcomes. How should physicians react to this and how should they contribute?

A: One positive aspect of managed care is that it has raised such questions as: 'Why do you do that?' and 'Why is it done that way?' Where we don't know the answers, we try to collect data so that we can answer the questions. Where we do have data, physicians are sometimes surprised to see that something they've always done 'the way they were taught' may not be the most effective high-quality care.

When it comes to using guidelines to improve the quality of care, physicians should be right in the middle of forming the organizations to do this work and of meeting the demands of managed care.

If the primary goal of a physician management company is to show physicians how to increase the bottom line without improving the quality of care, then physicians need to look at that organization carefully, perhaps even with a somewhat jaundiced eye.
“For physicians to sign contracts that force them to follow ‘cookbook medicine’ rather than to use the judgment they’ve been trained for is certainly not the best quality of care and probably borders on being unprofessional.”
business plan that will tell potential investors why the plan is a good deal.

Q: One current trend is the backlash against HMOs, which seems to be growing in fury at the state and federal levels. Is this an important phenomenon?

A: Yes, it is. It's primarily patients who have had a negative experience with the health care system, or a close friend or family member who has had a less than good experience. We have a superb health care delivery system in this country. It's not perfect, but it's very good, and patients have come to expect the best from this system. When something other than the best occurs, they look for reasons. When the reason appears to be a bureaucratic or a system failure, they tend to retaliate.

At the same time, there are some superb HMOs out there, and HMOs—and managed care in general—have done some very good things for medicine, including asking us to be accountable for the decisions we make and why we make them. Conversely, there also have been some HMOs that have been driven by the almighty dollar. They have tried to squeeze one more dollar out of the premium.

The backlash that we're seeing is from people who have had a less than good experience. What we're seeing now is simply the settling around something that took off quickly, was embraced by most health care purchasers, and then was found to have some flaws. People are saying, 'I thought you promised me a rose garden and now I think I have wild flowers.'

Q: Another phenomenon is the shift from a system that once used primary care gatekeepers almost exclusively to a system that allows access to broad panels of specialists. This trend is a form of HMO backlash in that allows access to broad panels of specialists. This trend is a form of HMO backlash. Is the AMA's position on medical savings accounts and the importance of having the Code of Ethics of Professionalism being what drives our decision making? That will give us the proper measuring stick when we're facing dilemmas in bureaucratic demands or in contracts. Our patients would like to see us strongly recommit to that ethical ground. My second goal is to help physicians see the choices and the opportunities they have in a market that continues to change and to generate a considerable amount of discomfort for them.

A: From a policy perspective, we believe strongly that patients ought to have choice of the system of care, and they ought to have an opportunity to understand what the implications of that choice are. However, frustrated some physicians get by fairly restrictive HMOs, if those are the ones that are the least expensive forms of care, patients certainly have the right to vote with their pocketbooks. They have the right to accept restrictions in exchange for a lower price. We believe variations on that theme should be allowed, whether by doing away with primary care gatekeepers or by having patients pay more if they go out of the plan for care. Patients ought to have an opportunity to buy the health plan that best serves their needs and along with that opportunity comes the responsibility to understand the choice they've made. It's not uncommon in this country for someone to choose a health plan based on price, but then cry foul when an unexpected illness comes along.

As a primary care physician, I believe the vast majority of patients would be better served if they had a primary care physician who would help them decide when they need to go to which specialist and who could coordinate other aspects of their care.

To young physicians today, I think the message must be extraordinarily clear: Board certification is important and you ought to pursue the appropriate training and certification processes in order to have that ticket.

Q: In closing, what do you hope to accomplish in the next three years as the AMA's top position official?

A: My first goal is to reiterate to physicians why we went into medicine and the importance of having the Code of Ethics of Professionalism being what drives our decision making. That will give us the proper measuring stick when we're facing dilemmas in bureaucratic demands or in contracts. Our patients would like to see us strongly recommit to that ethical ground. My second goal is to help physicians see the choices and the opportunities they have in a market that continues to change and to generate a considerable amount of discomfort for them.

The AMA has obligations to our profession. Our first obligation is to follow ethical standards. But we also have an obligation to help physicians survive the changes that are buffeting them. So, if we can achieve these two goals, it will have been a very successful three years.
Antitrust Rules Govern Group Practice, Network Formation

By Edward B. Hirshfeld, JD

Editor's Note: This column is the first of a series on issues involving organizational law for physicians. The column will be written by staff members of the American Medical Association's Health Law Division. It marks a new partnership between Physician Practice Options and the AMA.

Some physicians respond to managed care by forming a group practice or network. Their goal is to deliver high-quality services at a competitive price to attract patients and gain bargaining power. Although this response is legal under antitrust laws because it enhances price and quality competition for patients, physicians are not allowed to form groups or networks that could exercise market power—in other words, restrict output and raise fees against payers' wishes. Federal regulators have drafted guidelines to limit both the size of group practices that can be formed by mergers and the size and characteristics of networks formed by independent physicians. It is important that physicians forming such groups or networks understand these guidelines.

Group Practice Formation

Antitrust laws favor enterprises created when individuals merge their business or professional operations to form one entity, such as a group practice. Such enterprises are presumed to be a competitive response to market conditions unless they are large enough to exercise market power. The extent to which a merger will increase concentration of ownership in a market determines its legality under section 7 of the Clayton Antitrust Act. Larger mergers are allowed in unconcentrated markets than are allowed in concentrated markets.

The 1992 Horizontal Merger Guidelines, issued by the U.S. Department of Justice and the Federal Trade Commission, set forth a formula for evaluating the effect of a merger on market concentration. To use the formula, the market share of each market participant must be calculated both before the merger and as it will be after the merger. The pre- and post-merger market shares of each participant are then squared, and each set of squares (pre- and post-merger) is summed. Each sum is called the Herfindahl-Hirschman Index, or HHI, a measure of market concentration. The pre- and post-merger HHIs are then compared.

If the post-merger HHI is less than 1,000, the market is deemed unconcentrated and the merger likely would be allowed. If the post-merger HHI is between 1,000 and 1,800, the market is deemed moderately concentrated, and federal regulators (the Justice Department and the FTC) may prosecute the merger if it would increase the pre-merger HHI by more than 100 points. If the post-merger HHI is greater than 1,800, the market is deemed highly concentrated, and federal regulators may prosecute if the merger would increase the pre-merger HHI 50 points or more. Mergers that make the market highly concentrated are much more likely to be prosecuted than mergers that make the market moderately concentrated.

Market Concentration

Squaring the post-merger market share of the merging parties provides a rough idea of the likely legality of a proposed merger. Suppose a proposed merger would result in a group practice with a market share of 30%. The square of 30% is 900, which is close to 1,000. It is highly unlikely that the sum of the squares of the market shares of the rest of the participants will be less than 100, therefore the post-merger HHI is likely to be more than 1,000, which indicates a market moderately concentrated and a merger federal regulators may investigate. When a merger results in a market share of 43%, the square is 1,849, meaning the merger has resulted in a market share that by itself carries the HHI over 1,800 and into the zone in which the market is considered highly concentrated. Such a merger would be investigated.

As the size of a market increases, the market share of the merging parties decreases, making it less likely that the merger will result in an impermissible degree of concentration. Therefore, defining the size of the market may determine whether a merger is legal. Doing so requires defining both a product and a geographic market.

“The extent to which a merger will increase concentration of ownership in a market determines its legality.”

Edward B. Hirshfeld, JD, is vice president of the American Medical Association, Health Law Division.

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pany, might enter the market if the merging physicians attempted to raise prices. Entry of a new firm into the market increases competition, decreases the level of concentration by decreasing the market share of all of the existing firms, and lowers the HHI.

These size limits apply only to growth by merger. A group practice generally is allowed to grow without limit by adding physicians from outside the geographic market.

Network Formation
Physician networks are subject to more antitrust limits than group practices are. Although federal regulators recognize that networks can offer the same benefits to a market as a group practice can, they are concerned that individual network physicians might use the network to coordinate the prices they offer to purchasers that have not contracted with the network. Doing so would be price fixing. To prevent such price fixing, federal regulators regulate network size and require that networks have certain characteristics that they believe offer benefits to the market.

The required characteristics are listed in the publication 1996 Statements of Antitrust Enforcement Policy in Health Care. Federal regulators require a network to have at least one of the following characteristics:

- It must use the messenger model, or
- The physician members of the network must share substantial financial risk, or
- The network physicians must be clinically integrated.

The messenger model allows a network to arrive at fee arrangements with payers without any fee agreements among the physicians. The physicians appoint a messenger who communicates individually with each physician about the fee levels that the physician is willing to accept. There are no restrictions on who can act as the messenger, but it is easier to demonstrate compliance with the messenger model if someone other than one of the network physicians assumes the role. Commonly used messengers include attorneys, business consultants, medical society executives, and hospital executives.

The physicians may not communicate with each other about or agree on the fee levels. Each physician may preauthorize the messenger to accept from payers offers that fall within a fee range acceptable to the physician. The messenger may then create a schedule showing the percentage of physicians who would accept an offer at a given fee level and may present the schedule to payers. The messenger may enter contracts with payers on behalf of the physicians who have authorized acceptance at fee levels

“Although federal regulators recognize that networks can offer the same benefits to a market as a group practice can, they are concerned that individual network physicians might use the network to coordinate the prices they offer to purchasers not contracted with the network.”

Size Guidelines
The size guidelines for exclusive networks differ from those for nonexclusive networks. In exclusive networks, the physicians do not contract individually with other networks or health plans. Exclusive networks qualify for an antitrust safety zone, meaning federal regulators will not bar their formation, except in extraordinary circumstances, if their members share substantial financial risk and they do not account for more than 20% of any specialty in the market. Larger networks may be legal, since the HHI formula used to evaluate whether a merger is too large may be used to evaluate the upper limit on the size of exclusive networks.

A nonexclusive network qualifies for a safety zone if its members share substantial financial risk and do not account for more than 30% of any specialty. Nonexclusive networks can be of unlimited size provided they do not engage in or facilitate any anticompetitive conduct. Large nonexclusive networks should have procedures designed to prevent such conduct.

Editor’s note: To get a copy of the 1992 Horizontal Merger Guidelines or the 1996 Statements of Antitrust Enforcement Policy in Health Care, readers may visit the Web site of the Antitrust Division of the U.S. Department of Justice at gopher@justice.usdoj.gov or http://www.usdoj.gov, or write to: Gail Kursch Director, Health Care Task Force Antitrust Division U.S. Department of Justice Constitution Avenue and Tenth Street, NW Washington, D.C. 20530.
As the need for capital to fund expansion and build infrastructure for physician organizations continues to grow, it is fueling activity in the capital markets for physician practice management companies (PPMCs). Since June 30, five PPCMs have filed for or completed initial public offerings (IPOs); two PPCMs have filed for secondary equity offerings; one has filed a shelf registration; one has completed a private placement; and one has completed two debt offerings. Combined, the 10 companies are raising $1.2 billion (see Table 1). Despite the sometimes turbulent market for PPCM stocks, PPCMs are on track to raise over $2.4 billion in 1997, 30% more than they raised last year.

Investors continue to capitalize the PPCM sector in exchange for attractive returns, which are generated primarily by rapid consolidation in the industry. The number of PPCMs is growing in excess of 20% per year just through acquisitions and affiliations with physician clinics and networks. But investors also look at a PPCM’s ability to bring value to clinics by adding efficiencies and streamlining operations. Same-market growth is a key indicator of a PPCM’s ability to improve the operations of practices it has held for at least a year. Many PPCMs have reported same-market growth rates of 12% to 20% per year.

Of the existing 40 publicly traded PPCMs, the majority are single-specialty PPCMs. And, as more specialists feel the effects of managed care, more single-specialty PPCMs are being formed to help them succeed in a dynamic market environment that requires more capital. Today, there are 24 publicly traded single-specialty PPCMs, whereas there were only 17 at the end of last year. What’s more, of the five PPCMs that have filed for or completed IPOs since June 30, all are single-specialty PPCMs: Three are dental practice management firms; two focus on eye care and pathology.

With more PPCMs filing for public offerings, investors are likely to become more discriminating in choosing where to put their money. The companies that will attract that capital will be those that distinguish themselves from their competitors through acquisition growth and superior operational ability.

Table 1: Recent Offerings by Physician Practice Management Companies

<table>
<thead>
<tr>
<th>Company/ ticker</th>
<th>Headquarters</th>
<th>Description</th>
<th>Offering type (in $ millions)</th>
<th>Offering size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Health Corp./ ADVH</td>
<td>Tarrytown, N.Y.</td>
<td>Multispecialty</td>
<td>Secondary offering, filed 9/8</td>
<td>$47.0</td>
</tr>
<tr>
<td>AmeriPath Inc./ PATH</td>
<td>Riviera Beach, Fla.</td>
<td>Pathology</td>
<td>IPO, filed 8/25</td>
<td>$70.0</td>
</tr>
<tr>
<td>Coast Dental Services Inc./ CDEN</td>
<td>Tampa, Fla.</td>
<td>Dental</td>
<td>Secondary offering, filed 8/26</td>
<td>$36.0</td>
</tr>
<tr>
<td>Complete Management Inc./ CMI</td>
<td>New York</td>
<td>Multispecialty/ primary care</td>
<td>Shelf registration, filed 9/5</td>
<td>$200.0</td>
</tr>
<tr>
<td>Dental Care Alliance Inc./ DENT</td>
<td>Sarasota, Fla.</td>
<td>Dental</td>
<td>IPO, filed 8/27</td>
<td>$24.0</td>
</tr>
<tr>
<td>IntegraMed America Inc./ INMD</td>
<td>Purchase, N.Y.</td>
<td>Women’s health</td>
<td>Private placement, placed 8/12</td>
<td>$9.6</td>
</tr>
<tr>
<td>MedPartners Inc./ MDM</td>
<td>Birmingham, Ala.</td>
<td>Multispecialty/ primary care</td>
<td>Threshold appreciation price securities, filed 7/9</td>
<td>$350.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Senior subordinated notes, filed 7/9</td>
<td>$350.0</td>
</tr>
<tr>
<td>Monarch Dental Corp./ MDDS</td>
<td>Dallas</td>
<td>Dental</td>
<td>IPO, priced 7/17</td>
<td>$35.8</td>
</tr>
<tr>
<td>OrthAlliance Inc./ ORAL</td>
<td>Torrance, Calif.</td>
<td>Orthodontic</td>
<td>IPO, priced 8/21</td>
<td>$31.2</td>
</tr>
<tr>
<td>Vision Twenty-One Inc./ EYES</td>
<td>Largo, Fla.</td>
<td>Eye care</td>
<td>IPO, priced 8/19</td>
<td>$21.0</td>
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Hospital Executives Predict Managed Care Trends

Consumer choice is becoming more important in health care, according to a new survey of hospital chief executives in the eastern United States. Providers are seeking to develop health care options that offer broad choices and deliver optimum care at affordable prices, according to the survey by Arthur Andersen's Healthcare Consulting Group, in New York. In response to demands from consumers, provider organizations are trying to lift restrictions and offer greater access to physicians while remaining cost effective.

“In short, the market is asking for a fee-for-service look-alike at HMO prices,” says Mark D. Oshnock, head of health care consulting in the East for Arthur Andersen.

The survey results show the following:
- 95% of responding hospital administrators predict that point-of-service plans will continue to flourish,
- 54% project that the market will move away from HMOs that require patients to see a gatekeeper physician before accessing specialty care, and
- 48% predict indemnity insurance will not disappear.

Among responding executives, 65% are developing physician partnering strategies so they can offer broader physician panels. These strategies involve developing affiliations with physicians rather than owning physician practices. In an effort to gain market share, 93% plan to do business in Medicare managed care, and 80% will participate in Medicaid managed care, 32% will acquire Medicare HMO licenses, and 27% will acquire Medicaid HMO licenses, the survey shows.

Most respondents (95%) believe reimbursement from payers will continue to decline and, as a result, hospital profitability will fall. Few hospital executives, however, expect their institutions to operate at a loss. To help boost revenue, 70% will invest heavily in outpatient centers. To contain costs, 88% plan to enhance information systems to gain efficiencies through improved information flow, and 58% will institute cost-reduction programs.

Comment: Some 94% of hospital administrators believe payers will continue to choose low-cost over high-quality providers.

Study Shows Doctors, Patients Concerned About the Quality of Care Nationwide

A new report from the Center for Studying Health System Change, in Washington, D.C., shows that 24% of U.S. doctors surveyed last year and earlier this year did not agree with the statement: “It is possible to provide high-quality care to all of my patients.” The study examined the nation’s attitudes toward health care from the perspective of both patients and doctors. Regarding patients, the report stated that nine out of 10 families surveyed nationwide were satisfied with their health care in the last year and earlier this year, but one-quarter found their access to medical services limited compared with three years ago, according to The Los Angeles Times.

The researchers surveyed, by telephone, 23,000 families in 12 metropolitan areas and 9,200 physicians nationwide since last year and earlier this year. The results were released this fall.

The concerns among doctors reflect the growth of managed care, the newspaper said. “When you have to go through a number of hurdles to get the medical plans to agree to do some of the things you want to do for your patient—and you find roadblocks—then the quality issue comes up,” Stanley Lowenberg, MD, told the newspaper. Lowenberg is an ear, nose, and throat specialist in Orange, Calif., and president of the Orange County Medical Association.

About 20% of primary care physicians reported encountering difficulty in getting help from a top specialist when needed.

Comment: The public should expect a lower level of service if it wants to cut costs, Paul Feldstein, a professor of health care management at the University of California at Irvine, told the newspaper. Often, patients want a high level of service and lower costs: “If people were willing to pay more, they would have more access.” But Felix A. Schwarz, executive director of the Health Care Council of Orange County, said the patients who suffer the most are those who can least afford to pay more.

Automakers Say Cost Control Has Failed, New Approaches Needed

The nation’s largest automakers have found cost control has produced limited results and are now turning to improving health care quality, according to the Detroit News. “Costs improve when quality improves,” Jim Cubbin, executive director of health care initiatives for GM, told the newspaper. “This is not altruism; it is good business strategy.” Chrysler executives say that focusing on cost control has reached its limit and that continuing to do so will affect health care quality negatively.

The automakers have adopted new programs that focus on educating employees about health issues, on collaborating more closely with doctors and hospitals to improve quality and the effectiveness of care, and on managing chronic diseases more efficiently.

Ford, which is helping physicians to implement efficient procedures, has found that variations in practice patterns may at times affect quality adversely. Such variety may mean patients are given an outdated or needlessly expensive treatment, the newspaper said.

George Xakellis Jr., MD, Ford’s director of health care quality, has been asked to help physicians prescribe more uniform treatments. When he finds variation in physician treatment patterns, he will use medical evidence to advise physicians on how best to treat an illness or injury. Xakellis’s efforts are designed to deliver the best health care while eliminating unnecessary costs.

Comment: In the 1980s, Ford began to empower patients and the public by issuing a report card on the cost and quality of area hospitals. Today, Ford’s report card is a collaborative effort with the hospitals, and GM and Chrysler are involved now.
Government Cuts Residency Programs

To reduce the number of physicians trained each year, the federal government will pay more to teaching hospitals nationwide if they cut the number of physicians they train. Consumer groups and health economists say a physician surplus exists, even though many rural and inner-city areas have shortages, and general practice and family doctors are needed widely.

To encourage hospitals to cut training slots for new medical school graduates, the federal Health Care Financing Administration, which administers Medicare, will continue to pay fully for hospital teaching programs that discontinue 20% to 25% of student positions. Hospitals participating in the voluntary program will be expected to cut specialized residencies, such as those in anesthesiology or plastic surgery, while maintaining or raising the number of students in training for general practice. To fill gaps left after the cuts, the hospitals will be encouraged to use other health care professionals, such as nurse practitioners and physician assistants.

Earlier this year, the Clinton administration began paying teaching hospitals in New York not to train as many new physicians as they had in the past. This pilot project is now being expanded to all 1,250 teaching hospitals in the United States.

Comment: In the first two years, hospitals that cut residency slots will receive the same amount they would have received otherwise, an average of $100,000 per resident per year. In successive years, payments will be reduced to zero. The Congressional Budget Office estimates that $900 million will be saved by 2002 as the resident slots and subsidies are phased out over five years.