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May 1997

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Two Bills in Congress Would Create Opportunities for PSOs

Provider Groups Support Legislation; State Regulators, HMOs Oppose It

Legislation pending in Congress would loosen regulations that prohibit physicians and other providers from developing provider-sponsored organizations (PSOs) to serve Medicare patients nationwide.

Bills being considered in both Houses would exempt PSOs from state insurance licensing and solvency requirements for four years and would allow them to serve the growing Medicare population. The bills also would allow PSOs to develop Medicare-risk contracts and exempt them from federal rules that require at least half of a Medicare-risk HMO's enrollees to be members of a commercial health plan.

Recognizing that Medicare pays for as much as 60% of all hospitalizations and 40% of all outpatient care, physicians and other providers believe the financial opportunities of the proposed legislation are significant. The bills have the support of provider organizations such as the American Hospital Association (AHA), the Catholic Health Association, and the Federation of American Health Systems.

But the legislation faces stiff opposition from the National Association of Insurance Commissioners (NAIC) and the American Association of Health Plans (AAHP). Eliminating consumer protections built into state-licensing and capital requirements would threaten the stability of the health care system, say the NAIC and the AAHP. Currently, insurance commissioners regulate health insurance activities in the states. By having the federal government regulate

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Definitions: PSOs and PSNs

A provider-sponsored organization (PSO) delivers a range of services, including hospital, physician, and ancillary care, such as radiation or specialty services. PSOs may contract with HMOs, Blue Cross and Blue Shield plans, or traditional indemnity insurers or contract directly with employers or groups of employers.

To many observers, the term provider-sponsored network (PSN) is interchangeable with PSO. But others believe PSNs are different from PSOs because they accept risk, says Jacque Sokolov, CEO of Advanced Health Plans Inc., health care consultants in Los Angeles.

Since they contract directly with individuals, employers, and other payers, risk-bearing PSNs are similar to risk-bearing HMOs, according to a 1994 study by Virginia's Joint Commission on Health Care. Both risk-bearing PSNs and HMOs are established as provider networks, integrate insurance functions and the delivery of health care, operate on prepaid revenue, use managed care cost control strategies, and limit provider participation based on capacity.

EDITORIAL

Where We Stand on Managed Care

Readers often ask us where we stand on certain issues, particularly our position on managed care. While we are neither for nor against managed care as a method of reimbursement or of delivering health care, our mission is to offer practical, real-world advice to physicians about how to survive and thrive under managed health care systems.

Tempering Excess

We believe physicians need to recognize that managed care is present and growing in most health care markets nationwide. Since it is forcing all providers to change significantly how they practice medicine, physicians who understand the issues behind managed care and adapt most quickly will be better off than those who wait.

Moreover, we believe physicians need to be involved in tempering managed care's excesses. Simply denying care is ineffective and unjust, and arbitrary guidelines that treat all patients similarly regardless of their clinical condition need to be amended. Rules that prohibit physicians from speaking openly and honestly with patients should be eliminated. And, routing patients through primary care physicians is neither smart nor cost effective when patients have conditions that demand specialty care.

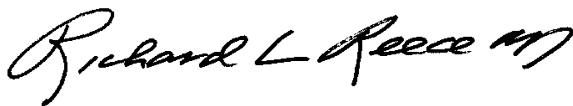
Nevertheless, managed care has both logic and inevitability on its side. Since 1993, membership in HMOs has risen 33% and membership in PPOs has risen 40%. More than 50% of Americans and 77% of all workers are enrolled in managed care. Most physicians (85%) have a managed care contract in place, and more than 90% of all members in Blue Cross and Blue Shield plans will be in managed care by 2000.

Sound in Theory

Indeed, many of the theories behind managed care are sound. Providers need to shift their attention from inpatient care to more appropriate, alternative sites outside of hospitals. The system should concentrate more on wellness, and physicians need to standardize care practices and manage quality more rigorously.

The reality is that government payers and businesses of all sizes have embraced managed care as the preferred system for controlling costs. At the same time, almost all other alternatives have been rejected.

We differ with many of managed care's supporters who say care directed by HMOs can be the most effective care. We believe physicians should be making all decisions about care for patients. We also believe that the single best approach for *Physician Practice Options* is to inform physicians about how to acquire the tools they need to deliver the best care under these conditions. Armed with these tools, physicians will be able to demonstrate that managed care can deliver quality care at the lowest justifiable cost—and then they will be free of today's onerous and ham-fisted oversight mechanisms. For now, however, that conclusion is simply a theory.



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Physician Practice Options is published 12 times annually by Premier Healthcare Resource, Inc., Chatham, NJ

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

COMMENTARY

Columbia/HCA Investigation Raises Questions About Medicare Billing

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

Columbia/HCA Healthcare Corp., the nation's largest health care system, is being investigated by federal authorities for Medicare-billing procedures and for its physician-referral practices. In March, more than 100 agents from the FBI, the Internal Revenue Service, and the federal Health Care Financing Administration seized billing records and other documents from about two dozen offices of physicians affiliated with Columbia/HCA in El Paso, Texas. The collecting of documents resulted from an investigation by HCFA into Columbia's Medicare billing practices, according to an article in *The New York Times*. HCFA was trying to determine "if certain Columbia hospitals engaged in a practice known as upcoding, in which hospitals receive larger payments from Medicare by inflating the seriousness of illnesses they treat," *The Times* said. HCFA Executive Director Bruce Vladek confirmed that HCFA was conducting a specific review of coding procedures at Columbia hospitals. In a public statement issued March 31, Columbia's public relations office said, "HCFA had not informed the company of any such review."

James B. Nuckolls, MD, CEO of Blue Ridge Primary Care, a medical group in Galax, Va., expected more investigations as a result of changes in how patients are treated. "We are going to see more of these types of investigations into Medicare billing practices, especially the use of treatment management codes, as medicine moves more to outpatient treatments than to inpatient," says Nuckolls, a member of the Advisory Board of *Physician Practice Options*. The investigations will go beyond hospital systems, such as Columbia, and into physicians' offices, he says. "These changes in treatment practices, and the cost scrutiny now taking place in Washington, are bringing a whole new regulatory fever."

The Times reported that federal, civil, and criminal investigators were examining whether it is illegal for Columbia doctors to make referrals to services associated with Columbia hospitals, such as home care and rehabilitation services, if the doctors have a financial interest in the services. In its statement, Columbia said it believes the "structure of its physician ownership is in compliance with current law. If the law is changed, we will change our structure accordingly." Columbia's operations include about 350 hospitals, or 7% of the nation's total, in 38 states, as well as about 150 surgery centers and hundreds of related medical operations. Columbia is Medicare's single largest vendor. Medicare reimbursement represents 36% of the company's total revenue.

A Year-long Investigation

The Times coverage resulted from a year-long investigation by the newspaper into Columbia's business practices and involved a computer analysis of more than 30 million billing records of Medicare patients admitted to hospitals in Texas and Florida in 1995. The newspaper matched the records of those patients with bills for hospital readmissions, admissions to rehabilitation and skilled nursing units, outpatient services, and physicians' bills within 30 days of discharge. Hospital stays were grouped into 1,500 categories by type and severity of patient conditions.

As a result of its analysis, *The Times* concluded that many Columbia hospitals bill Medicare for high-paying respiratory treatments far more often than competing hospitals serving similar populations do. Federal authorities called such findings an indication of possible overbilling of the Medicare program, *The Times* said.

In Texas, where Columbia has its largest number of hospitals, Medicare paid unusually high amounts for Columbia patients who received costly services, such as home care, *The Times* said. "Mainly because of Columbia's use of these services, Medicare... pays nearly 10% more for treatment that begins at a Columbia hospital than at other Texas hospitals," *The Times* said. "That means extra federal payouts of nearly $50 million in 1995, the last year for which data are available, the analysis shows."

Medicare pays a fixed rate for treatment of each of about 470 coded illnesses. The rates vary sharply. The more severe the illness, the more Medicare pays. It is illegal, HCFA says, for a hospital to bill for a more severe illness than it actually treats since the hospital would be paid more for a more severe illness.

> **"We are going to see more of these investigations into Medicare billing practices and the investigations could go beyond hospital systems, and into physicians' offices," says James B. Nuckolls, MD, CEO of Blue Ridge Primary Care, a medical group in Galax, Va.**

The newspaper's investigation focused on Florida and Texas, where Columbia's hospital holdings are concentrated. In Texas in 1995, five Columbia general-medicine hospitals ranked at the top for the proportion of cases billed at the highest Medicare rates, and, in Florida, the top six facilities when ranked by total billing in 1995, were Columbia facilities, *The Times* said.

The practice of upcoding has long been a problem for HCFA. Federal studies in

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recent years have shown that upcoding cost Medicare hundreds of million of dollars. If upcoding is uncovered at a facility, HCFA seeks restitution. If a pattern of overbilling is determined, a fraud investigation can be started. While few cases have been prosecuted, Medicare overbilling related to upcoding and other activities has been identified at numerous hospitals and among large numbers of doctors, *The Times* said. President Clinton recently called for a crackdown on Medicare providers that defraud the system and asked Congress to consider strengthening criminal penalties for such abuses and banning any provider convicted of Medicare fraud from continuing as a Medicare provider.

Conflicts of Interest?

In addition to possible overbilling, federal investigators were examining whether Columbia illegally encouraged network physicians to refer patients to outpatient facilities in which both Columbia and the doctors, through investments in Columbia, have a financial interest, *The Times* reported.

The newspaper reported that its investigation into the referral patterns of 62 Columbia physicians in the Miami area demonstrated that after those doctors invested in two local Columbia hospitals in early 1993, the Miami Heart Institute and Cedars Medical Center, they increased their admission referrals to those hospitals over the next three years by 13% and decreased their referrals to other hospitals by 22%. Columbia said *The Times* data are flawed and do not reflect the referral practices of a sufficient number of physicians to signify a pattern.

"The reality is that as the industry moves from nonprofit (health care) systems to more for-profit systems, these ethical questions are going to continue to increase," says Jacque Sokolov, MD, CEO of Advanced Health Plans Inc., health care consultants in Los Angeles. "A major problem with the way Columbia does things is that it has no reward system for anything but profit."

Since it began acquiring hospitals about 10 years ago, Columbia has invited physicians to invest in the hospitals where they practice, using such investment as an incentive for physicians to join Columbia's network. At the same time, the company has built a profitable network of medical services affiliated with its hospitals, such as home care and rehabilitation facilities. Government investigators were examining whether those two initiatives might, in combination, violate a 1992 law prohibiting doctors from referring patients to facilities in which they invest, *The Times* said. Physicians are allowed to invest in hospitals, but are barred from referring patients to medical businesses, such as home care agencies, if they have a financial interest in those businesses.

"If we have physicians who are referring patients to home-care agencies or skilled nursing facilities in which they have an ownership, that may very well be against the law," Vladek told *The Times*. HCFA was considering whether to issue rules specifically barring physician-investors from referring patients to any outpatient facilities included in their investment.

"These types of arrangements can lead to conflicts of interest, perhaps not legal conflicts, but ethical conflicts, by appearing to color the type of care a physician may prescribe," Sokolov comments.

Outpatient referrals concern federal officials because about 25% of Medicare payments went to such facilities in 1995, compared with 9% in 1990. The increase results from a Medicare incentive for physician referrals to treatment alternatives less costly than inpatient care. Medicare reimbursements for those services are based on provider costs, not a preset amount.

In Texas, Columbia provided after-hospitalization services far more often than its competitors did, *The Times* said. Post-hospitalization treatment based on Columbia network physician referrals cost Medicare 23% more than did referrals by competing networks.

All health care systems, including Columbia, should place increased emphasis on quality and outcomes measures as financial incentives, rather than profit-sharing, says Sokolov. "I am in favor of physician incentives as a consequence of providing quality care," he says.

Columbia/HCA Statistics

Columbia/HCA, based in Nashville, Tenn., is the nation's largest operator of for-profit hospitals. Last year, Columbia/HCA had net profit of $1.5 billion on more than $20 billion in revenue.

- It operates more than 350 hospitals in 38 states, about 7% of the nation's total. It also owns more than 150 surgery centers and hundreds of related medical operations.
- It employs more than 3,000 physicians.
- It is Medicare's single largest biller, and Medicare reimbursement comprises 36% of its total revenue.
- It treats about 125,000 patients a day and with 285,000 employees, it is the ninth largest employer in the United States.

Investment Practices

In yet another matter attracting interest, Columbia was reported to be forming a network of 200 physicians in Panama City, Fla., in which it offered physicians a 16.8% return in the first year on an investment of $15,000 and promised returns as high as 24.9%, according to an article in *The Wall Street Journal*. The network would be affiliated with Gulf Coast Medical Center in Panama City, a hospital owned by Columbia. A confidential memo from Columbia to Panama City physicians said such investments could face regulatory risks, *The Journal* said.

Quoting from the memo, *The Journal* reported: "No assurance can be given that the partnership, its operations, or any investor will not be reviewed and challenged by enforcement authorities empowered to do so, or that, if challenged, the partnership would prevail." Outlining an aggressive growth strategy for the medical center, the memo proposed to increase admissions 34% in the next five years and to triple the facility's net income to $28.7 million by 2001, *The Journal* said.

"We need economic incentives to help join the various components of our health care system together," says Nuckolls. "The question will continue to be whether those incentives lead to overutilization. What can be dangerous is unscrutinized ownership of health care systems. These arrangements need to be scrutinized, not just by the government, but by the private purchasers of care. Educated purchasers are the essential element of a good system." ■

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PSOs, the government would create two sets of regulations, one for PSOs and one for other insurers.

"We oppose a dual regulatory environment," says Josephine Musser, president of the NAIC and insurance commissioner in Wisconsin. "We oppose different sets of regulatory structures for risk-bearing entities. That creates an unlevel playing field and threatens the guarantees of solvency that consumers require of insurance plans."

Fostering Competition

The AHA defines PSOs as affiliations of health care providers, such as physicians and hospitals, that provide health care services under contract with insurers, managed care organizations, or the government. PSOs also are called physician-sponsored networks (PSNs). PSOs are initiated, financed, and governed by health care providers and are often formed to deliver services through direct contracts with payers.

"Managed care organizations are willing to share some risk with provider organizations," says Elizabeth Gallup, MD, executive director of Community Health Partners, a PSO in Overland Park, Kan. "But they won't work with providers as partners. They'll allow physicians to assume risk, but not to pass on the administrative funds necessary to administer that risk. So PSOs go around HMOs and directly to consumers."

The bills in Congress would make direct contracting with Medicare participants easier and less costly for PSOs by superseding state regulations. In March, the Provider-Sponsor Organization Act of 1997 (S.146), sponsored by Sen. Jay Rockefeller (D-W.Va.), Sen. William Frist (R-Tenn.), and five others, was being considered by the Senate Finance Committee. The House's bill, the Medicare Provider-Sponsored Organization Act of 1997 (H.R. 475), has 24 cosponsors, and in late March it was being considered by the House Commerce Committee's Subcommittee on Health and Environment. Nearly identical, the two bills are considered to be Medicare-reform measures. They are designed to eliminate state and federal barriers to PSOs that want to develop risk contracts for Medicare recipients and to foster competition between PSOs and managed health plans. No date was set for consideration of either bill by the full Senate or House.

The federal Health Care Financing Administration (HCFA), which administers Medicare and Medicaid, defines a Medicare-risk contract as one in which a provider accepts a fixed, or capitated, fee to provide all health care services to Medicare beneficiaries. The insurer must provide all necessary and covered health services, and is therefore at risk for a financial loss if the cost of those services exceeds its fee or premium.

Solvency Issues

Under solvency requirements in place in every state, insurers need to set aside cash to protect all parties to the health insurance contract. Solvency requirements guarantee that if a consumer or an employer pays a PSO for coverage and the provider goes bankrupt, the customer is protected. In general, insurers are required to set aside at least $1.2 million, and sometimes more.

"If these entities cannot afford minimal solvency requirements, they shouldn't be in business," Musser says of PSOs. "They are simply

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At a Glance: PSOs and PSNs

The terms "provider-sponsored organizations" (PSOs) and "provider-sponsored networks" (PSNs) are used widely and interchangeably to refer to many different kinds of operations. Three of the most commonly discussed forms of PSOs are physician-hospital organizations (PHOs), independent practice associations (IPAs), and group practices. The following are definitions of the terms as used in *Physician Practice Options*.

PHOs are joint ventures between hospitals and physicians that are established to create a single marketing and contracting entity.

IPAs are physician organizations that contract with payers (either employers or more commonly with managed care organizations) on behalf of a group of independent physicians to provide health care services to a group of plan participants.

Group practices are physician groups that provide health care services and share income and expenses. The physician group practices work together at a limited number of facilities.

Integrated delivery systems are organizations of health care providers that offer a broad range of services. An IDS is a single legal entity, has a single governance structure, and signs contracts with one signature representing all physicians. Peter Kongstvedt, in his book, *The Managed Health Care Handbook* (Aspen, Gaithersburg, Md., 1996, third edition), says that "an IDS should optimize cost and clinical outcomes, accept and manage a full range of financial arrangements to provide a set of defined benefits to a defined population, align financial incentives of the participants (including physicians), and operate under a cohesive management structure."

(Continued from page 5)

putting the consumer at risk."

States also require insurers to meet licensing requirements, which means meeting certain standards of quality and filing periodic reports about the number of people served, what care was denied and to whom, and other utilization information.

For the first four years after the legislation is enacted, the states would no longer be responsible for oversight of PSOs. Instead, the federal Secretary of Health and Human Services (HHS) would ensure that PSOs provide "the full spectrum of Medicare-defined benefits on a capitated basis" and deliver "a substantial proportion" of Medicare services directly through their own physician members. The bills also would replace state solvency requirements with unspecified financial standards that would be developed by HHS and that "recognize that the core business of PSOs is health delivery, not insurance, and that their assets are used predominantly to deliver care, not to pay claims." HHS also would be responsible for drafting quality standards for federally regulated Medicare-risk PSOs. After four years, regulatory oversight of Medicare-risk PSOs would shift to the states if they adopt regulations virtually identical to those developed by HHS.

Licensing Eliminated

The most disturbing provision of the bills is the proposal to eliminate state licensing of Medicare-risk PSOs, says Musser. "If these companies can come into a state and then leave without examination, they are putting everyone at risk—the consumer, the doctors, the hospitals," she says. "They can come in, take the money, and leave, leaving no money and no trace."

During a Senate Finance Committee hearing in March, Sen. Frist countered this argument, saying that "at the end of the four-year period, state licensure would be required as long as state standards are sufficiently similar to federal standards, and solvency requirements are identical. This approach marries the benefit of national standards for a national program with the benefit of the closer monitoring eye of state agencies.

"In addition, the overwhelming majority of state licensure requirements do not recognize the fact that PSOs differ from most insurers. Rather, states expect them to look and act like insurers. But they are not. They are caregivers. The bill requires that a substantial portion of services be provided directly by the PSO's affiliated providers, those that are under common control or ownership or who share substantial financial risk. This requirement ensures that a plan is not simply contracted out for services, but is the caregiver."

> **"The overwhelming majority of state licensure requirements do not recognize that PSOs differ from most insurers. States expect them to look and act like insurers. But they are not. They are caregivers."** — ***Sen. William Frist, D-Tenn.***

Before the same committee, Karen Ignagni, president and CEO of AAPH, criticized the lack of state oversight and said it could damage the faith Medicare beneficiaries have in privatization of health care.

'A Drop in the Bucket'

Jacque Sokolov, MD, CEO of Advanced Health Plans Inc., health care consultants in Los Angeles, believes that state oversight does not provide the certainty of either solvency or quality that Musser and Ignagni imply. "Different licensing requirements in 50 states remove the ability to control quality of care that would be inherent in centralized accountability," says Sokolov, a member of the Advisory Board of *Physician Practice Options*. "The federal government is in a stronger position, through a centralized administrative structure, to provide uniform and better outcomes and quality measurement safeguards.

"As for the $1.2 million solvency requirements, they are a drop in the bucket for consumer protection," Sokolov says. "What is needed are re-insurance requirements to make up for at least part of the variance

Four Examples: How PSOs Operate Under a Variety of Structures

Some PSOs are structured to engage in direct contracting with individuals, employers, and other groups, according to a report published in December by the National Association of Insurance Commissioners. Titled *The Regulation of Health Risk-Bearing Entities,* the report provides examples of PSOs and describes their operations briefly and includes two examples of PSOs that engage in direct contracting, U.S. Health Group and SecureCare of Iowa.

U.S. Health Group, in Columbus, Ohio, was formed by U.S. Health Corp., a hospital-owned entity in Columbus, and Medical Group of Ohio, an IPA in Columbus. U.S. Health Group owns U.S. Health HMO and a third-party administrator (TPA). The TPA administers PPO services in about 40 of Ohio's 89 counties involving about 50 hospitals, 4,000 physicians, and 130,000 covered lives. The premium paid to U.S. Health HMO, an entity recently licensed by the Ohio Department of Insurance, will be distributed to pay administrative and marketing expenses, contracting providers, and profits to the provider owners.

SecureCare of Iowa is a PHO licensed under Iowa state laws as an organized delivery system. The Iowa Department of Public Health has primary regulatory responsibility, but the state's Division of Insurance reviews its financial performance. The organization is affiliated with Mercy Hospital Medical Center, which is SecureCare's only hospital owner, and has 380 physicians who are stockholders. Of the 380 physician-owners, 100 are primary care physicians and the remaining 280 are specialists. As a group, the physicians own 50% of the entity, and the hospital owns the other 50%. SecureCare of Iowa contracts with about 100 employer groups. It currently does not contract with any individuals. It is discussing with other insurers and PHOs the possibility of renting its network but has not yet entered into any contracts to do so.

The NAIC report also includes examples of two PSOs that do not have insurance licenses: Advocate Health Partners and Lahey Hitchcock Clinic. Those PSOs that do not have insurance licenses generally do not structure their activities to engage in direct contracting activities but rather focus on building relationships with licensed health plans.

Advocate Health Partners (AHP), in Chicago, has a structure commonly referred to as a super-PHO. AHP is an organization that operates eight PHOs and two medical groups. AHP develops managed care and medical management strategies and does managed care contracting. Each hospital is affiliated with a PHO, and all PHOs are structured so that the hospital and the medical staff each own 50% of the PHO. The provider network involves eight hospitals and 3,500 physicians.

AHP contracts with multiple managed care organizations to bring business to Advocate PHOs and contracts for centralized medical management support. The PHOs contract with various providers to offer medical care and are responsible for local medical management and member and provider relations. A medical services organization is responsible for centralized claims, information systems, and administrative support. When the report was written, AHP was serving 150,000 capitated members.

Lahey Hitchcock Clinic (LHC), in Burlington, Mass., is a multispecialty group practice that employs more than 900 physicians at 60 sites in Massachusetts, New Hampshire, and Vermont. LHC was formed two years ago through the merger of two large multispecialty clinics, both of which were founded in the 1920s. Overall, it has 6,400 full-time employees. In addition to providing primary and specialty professional services, the LHC system includes two hospitals and a range of ambulatory care services. LHC is a component of the Dartmouth-Hitchcock Medical Center, in Hanover, N.H., and is organized as a nonprofit corporation. LHC provides services through a broad range of payer relationships, ranging from fee-for-service to fully capitated services. LHC currently has approximately 160,000 capitated lives. The compensation package for LHC physicians includes a salary and an incentive based on group performance. ■

between premiums and expenditures that could lead to financial problems."

In addition to taking oversight of Medicare-risk PSOs out of the hands of state regulators, the proposed legislation eliminates what is known as the 50-50 rule, a HCFA requirement that any managed care entity with Medicare-risk contracts must have at least half of its enrollment in commercial plans. "Medicare recipients use a significant degree of health care services," Musser says. "The purpose of the 50-50 rule is to be certain an entity's resources are not completely vested in this high-risk population. It is an additional consumer protection."

The 50-50 rule does not provide solvency protection, Sokolov counters. Also, it does not strengthen the quality of care received by Medicare beneficiaries, he adds. "The 50-50 rule just isn't necessary," Sokolov explains. "It was developed in an era when there were concerns that the quality of Medicare was significantly lower than that of commercial care. Under centralized quality controls for Medicare-risk PSOs, clinical accountability can be regulated, and Medicare recipients can be protected without the 50-50 rule."

HCFA has created seven demonstration projects for Medicare-risk PSOs that are exempt from the 50-50 rule and state licensing requirements. Four of the projects began on Jan. 1, and three began on March 1. They are Florida Hospital Healthcare System in Orlando; Memorial Sisters of Charity Hospitals Network in Houston; Health Plans of Pennsylvania and Health Partners of Pennsylvania, both in Philadelphia; Yellowstone Community Health Plan in Billings, Mont.; Ohio Health Alliance and the Mount Carmel Health System, both in Columbus, Ohio. Since the Florida Hospital Healthcare System began preparing for the project more than a year ago, it was the first to accept enrollees, and by March 1 had enrolled more than 1,500 Medicare beneficiaries.

"The truth is that solvency requirements and the 50-50 rule are really no more than barriers to market entry," Sokolov says. "HMOs now assuming Medicare risk don't want to lower the barriers. These so-called barriers to safeguard beneficiaries are there to keep small PSOs from entering the market." ■

Primary Care Guidelines Aim to Increase Practice Efficiency

Second of two parts

Q: *What is the purpose of Milliman & Robertson's Healthcare Management Guidelines, particularly the recently published volume on clinical practices for outpatient treatment?*

A: Volume Five of our Healthcare Management Guidelines was published in October 1996 in response to requests from Milliman & Robertson clients for practice guidelines covering outpatient treatment and pharmaceutical care. Since 1990, when we published Volume One (Inpatient and Surgical Care), we have produced seven volumes of health care management guidelines: Return-to-Work Planning (Volume Two), Ambulatory Care Guidelines (Volume Three), Case Management: Home Care (Volume Four), Outpatient and Pharmaceutical Care (Volume Five), Case Management: Recovery Facility Care (Volume Six), and Workers' Compensation (Volume Seven).

Volume Five was developed for primary care physicians who want to provide cost-effective, quality care for a population of patients. Since they see patients with symptoms, not a diagnosis, primary care physicians have to make many diagnostic, treatment, and referral decisions. The optimal treatment solutions are often complex and objective, and information is usually not readily available. Having these guidelines in one source enables providers to decrease variation in diagnostic workups, treatment, and referral of more than 120 outpatient conditions and incorporates information from Volume One on inpatient and surgical care, hospital admissions, and surgery indicators.

Richard Liliedahl, MD, *has been a health care management consultant with Milliman & Robertson since 1994. Prior to joining M&R, he served as medical director for two HMOs, Group Health Cooperative of Puget Sound and FHP Inc. Also, he served as a family practice physician for 18 years. A member of the advisory board of* Physician Practice Options, *Liliedahl has extensive experience helping physicians work in managed care settings by establishing quality management and effective utilization management procedures. Also, he has developed and negotiated capitation contracts that include practice guidelines. This interview was conducted by Richard L. Reece, MD, editor-in-chief.*

Q: *Has there been a large demand for the primary care volume?*

A: Yes. Providers have many questions regarding cost-effective management of health care, including primary care, specialty referral, and pharmacy costs. Managed care seems to control the inpatient cost, at least in the most mature markets, but everyone is trying to control outpatient costs. Therefore, the demand for this information came originally from our clients.

Q: *How did you develop these guidelines?*

A: Our process in producing the guidelines was to form panels of some six or so expert physicians and specialists who are or were in active practice and are familiar with the literature for the diagnosis in question. The consensus of the expert panel for each diagnosis was used to formulate the guidelines.

For Volume Five, members of the panel reviewed guideline drafts created by myself or Mulloy Hansen, MD, another Milliman & Robertson clinician consultant. Our goal was to create a clinical and management tool that would be useful to primary care doctors in a managed care environment who need this kind of information for a common diagnosis. Volume Five not only covers 120 common medical conditions and puts them into ICD-9 codes, but also it discusses diagnosis and treatment and includes indications for specialty referral, hospitalizations, and surgical invasive procedures.

Q: *Has there been a demand for all of the volumes since they were published? And if so, who is using them?*

A: All of our guidelines have been in demand this year. Volume One, for example, is now being used by providers delivering care to 40 million to 50 million covered lives. About 58% of the users of Volume One are providers, including physicians and hospitals. The rest are insurers, HMOs, and other provider organizations.

Q: *Do providers modify the guidelines to meet their individual needs?*

A: Some of the big, older integrated delivery systems and some of the larger HMOs have done a lot of work revising the guidelines to meet their local expectations. And some health plans that use them through their medical management or case management departments might also make some revisions.

But overall our experience has been that after doctors utilize one or two of the individual guidelines and become comfortable with them, they tend to accept the rest of them as they are.

Q: *Does M&R modify the guidelines based on feedback from users or do the users make their own modifications?*

A: Both methods are used. We try to codify and put on paper what commonly happens in managed care plans when primary care doctors are well trained and able to provide a majority of the care that patients need by diagnosis. We continue to get feedback from physicians and use that feedback when we update each volume. That process will continue to improve over time. But users who license the guidelines are also free to change them since they have copyright privileges.

The copyright privileges permit the user to reproduce a guideline—to attach it to a patient chart, for example. But licensing the guidelines provides other advantages as well. The organization can put an electronic version up on a network where physicians and other health care

professionals can access it, and the electronic version can be customized easily on-line. One other advantage for users that purchase the newest editions each year is that the renewal fee for the electronic version is 40% of the initial license fee, rather than the full cost.

The fee to license a volume is based on a sliding scale, depending on the number of MDs, physician assistants, and nurse practitioners in the group. The fee is $7,500 for as many as 80 such providers, and $45,000 for as many as 699. If the licensing organization is an HMO, the scale is based on the number of covered lives.

Q: *Have the guidelines been controversial?*

A: Some guidelines in Volume One concerning short lengths-of-stay goals we set for patients admitted to hospitals for some conditions have provoked debate. Otherwise, no, since they are intended to be goals and not rules.

Q: *Is Volume Five, then, a kind of a diagnostically driven* Physicians Desk Reference, *only simpler?*

A: Yes, that's a good way to put it.

Q: *Do you believe these guidelines have the potential for standardizing and improving the quality of care?*

A: Yes. What we've done, which most people haven't been able to accomplish, is to create a large, single set of guidelines that are readily available and easy to use. I think that is why big organizations have been able to disseminate them to their networks efficiently.

Q: *Do you have evidence that the routine use of these guidelines has lowered cost or changed practice patterns?*

A: Yes. We have seen our guidelines being used over the years and observed that they have affected how health care has been managed for certain populations. In fact, we have client data, especially from our user seminars, that demonstrate how a lot of health plans have become more efficient because of using these guidelines.

Every December, we conduct a user seminar in Scottsdale, Ariz., where people who use our work make presentations on how they have implemented specific guidelines and their results, and on how others can use the guidelines. Usually, several hundred current users attend the seminar, and we encourage them to connect with each other, especially physicians who share similar specialties or practice experiences.

"Our approach is to develop a diagnosis-driven formulary, in which we start with the diagnosis and then come up with the formulary by picking the best drug for a given diagnosis."

Q: *What percentage of the time are the guidelines for the 120 conditions in Volume Five applicable?*

A: We think they are applicable almost 100% of the time because we picked common diagnoses, and we've talked about appropriate first-line treatment. For drug use, we also provide second-line and third-line guidelines if there's a failure with the initial drug use. If a patient does not respond clinically to a therapeutic approach, we discuss when the patient should be referred to specialty care. We also discuss what to do if the patient gets clinically worse, and when he or she should be admitted to a hospital. And for each diagnosis, we talk about indications for surgical procedures. So, for the 120 diagnoses, the guidelines are applicable most of the time. I hate to say always. You can't say that in medicine, but the majority of time they can be used.

Q: *Are there conditions that fall outside of these 120 guidelines?*

A: Yes. But we are revising the volume this year to include the diagnoses that we don't cover, and we are updating each volume annually.

Q: *The use of pharmaceutical regimens is included in the guidelines for various conditions. How do you separate the interests of Milliman & Robertson from those of the pharmaceutical companies?*

A: We need to make this point very clear. We see ourselves as an independent consulting firm that produces objective information. Therefore, we have had absolutely no communication, conversations, or input from any drug companies in the development of these guidelines. We did all of this work independent of any input from any of them. And we intend to keep it that way so that people can trust the objectivity of what we do.

Q: *So you cite the drugs you deem are most appropriate and effective no matter which company manufactures them?*

A: Yes. For example, one approach that has become a norm within managed care plans is to create a formulary and then have physicians apply that formulary to patient populations. There is, however, evidence that very restrictive formularies may increase total health care costs, while decreasing the pharmacy portion of that total cost. So our approach has been to develop a diagnosis-driven formulary. For this formulary, we started with the diagnosis, came up with the formulary, and approached it from that viewpoint. We picked the best drug for a given diagnosis. We chose an expensive drug, for example, such as azithromycin to treat nonspecific urethritis in young males, because we know a one-shot approach in that patient population is more cost-effective in the long term than 10 days of treatment with doxycycline. Most formularies that are restrictive would not cover azithromycin but instead have 10 days of doxycycline as appropriate treatment. So this is not a restricted formulary by any means. It's a diagnostic-driven formulary and the number of drugs is probably average compared to other formularies in managed care.

Q: *Have the users of Volume Five found it easy to use and easily adaptable to their specific situations?*

A: Yes, we believe the users have found the guidelines to be straightforward, and easy to use because they include common conditions and list the average wholesale price of drugs. For a primary care doctor, the guidelines discuss the appropriate treatment for common conditions, describing the best and most appro-

M&R's Guidelines: What They Are and What They Are Not

Milliman & Robertson describes the seven volumes of its *Healthcare Management Guidelines* as optimal clinical practice benchmarks for treating common conditions for patients who do not have complications. Designed solely to support the efficient delivery of quality health care, they are not based on financial objectives or volume targets, and are not a prescription, a decision tree, or a set of rules for the practice of medicine, says M&R, health care consultants and actuaries in Seattle.

"Anyone who uses the guidelines as a basis for denying authorization for treatment without proper consideration of the unique characteristics of each patient or as a basis for denying payment for treatment received is using our guidelines inappropriately," M&R says in its product literature. "The purpose of the guidelines is to achieve higher quality care by minimizing variation and by reducing significantly different treatment patterns when patients are diagnosed and treated expeditiously."

Developed as goals for situations when everything goes well, the guidelines are not a substitute for clinical judgment, says M&R. They should be used to help clinicians identify the most efficient, quality practices for common conditions based on how other physicians have treated similar patients. They should be adapted to fit local needs and conditions, and attending physicians should always use their own judgment based on each patient's unique circumstances, M&R says.

When writing the guidelines, M&R consultants drew from current practices of active physicians and reviewed more than 35,000 inpatient charts throughout the United States. Each of the seven guidelines are updated each year as a result of reviews by users, practicing physicians, and academic physician advisers in specific areas of specialty.

The Actuary's Role

In specifying the relationship between cost and clinical quality, M&R notes that actuaries focus on the financial viability of the health care delivery system. "Actuaries did not create the guidelines," M&R says. Financial viability is necessary to provide the most care possible to the most people. Actuaries focus on the financial underpinnings of the health care system and help measure the financial risks associated with the delivery of health care, such as utilization rates, costs, trends, identification of opportunity, volatility, and risk.

"Clinical consultants address how care is actually delivered, and how it could be delivered more efficiently given the particular characteristics of a given health care system," M&R says. "Clinical practices ultimately drive the cost of the system. Actuaries and clinicians together identify the clinical and financial opportunities available, translate these opportunities into specific clinical practices, and measure the financial impact of the changes. It is a powerful and necessary combination if we are to continue to assert control over rising health care delivery costs." ■

priate drug. They also describe situations such as when the physician should make a specialty referral, or when a patient needs surgery. Clinical indications for each diagnosis are also included. And the procedures are applicable to nearly any situation that exists in managed care plans.

Q: *Regarding Volume Five, what has been the official reception among such organizations as the American Academy of Family Practice or the American Society of Internal Medicine?*

A: We have had no negative feedback, and in fact, have received suggestions from several organizations about input for our next edition. I can't comment on specific organizations and their issues, but there has not been any resistance. We have asked several primary care organizations to review the guidelines.

Q: *Health care cost control efforts often are compared with the effects of pushing on an inflated balloon: If you push on one side, it pushes out the other. What appears to be happening is that while inpatient utilization has dropped, outpatient utilization has expanded.*

A: Exactly. And once you move into the outpatient area, the most expensive items are specialty care and pharmacy costs. People spend all their time trying to manage things like primary care costs. Primary care costs are usually less than pharmacy costs, which is pretty amazing.

Guideline Users by Type

Type	Percentage
Providers	58%
Insurers, HMOs	30%
Other	12%
Total	100%

Source: Milliman & Robertson Inc., Seattle.

Q: *I have read that outpatient primary care costs are less than 10% of the medical dollar.*

A: Of a $100 premium, the primary care portion may be 10% to 12%, the pharmacy portion may be about 18% to 20%, and specialty care may be 25% to 40%, depending on the market. Then you have to include hospital care, at 10% to 15% for administration and profit.

But pharmacy costs may vary from $4 to $20 for a specific diagnosis in the commercial market. As a result, there's marked variation in what pharmacy costs are in a commercial premium. So, these guidelines are a useful tool for making pharmacy costs more predictable.

Q: *Some health policy makers believe physicians in local markets should develop guidelines to standardize care practices. But others say that guidelines developed locally can simply institutionalize bad practices. Do you have a recommendation on the issue of whether local physicians should develop guidelines or would physicians be better off getting a copy of guidelines developed by a national firm?*

A: We think we have a better alternative. They can license our guidelines and make changes, if necessary, and then save years of work and millions in research and development costs. ■

Survey Results Outline Capital Needs of Many Physician Organizations

Many physicians are learning that they need capital to build competitive practices under managed care. Consolidating into larger multispeciality and single-specialty groups allows physicians access to investment capital needed to buy information systems and to purchase other practices. Capital also is needed to hire managers with the experience in building physician organizations. Without capital, physician groups remain small and cannot compete with the much larger managed care organizations.

Once physician practices are consolidated, the participating doctors may see a reduction in overhead costs and a greater ability to generate revenue from ancillary sources, such as clinical laboratories and radiology and imaging services. Physicians in groups also can standardize practice protocols to eliminate redundancy and to deliver better patient service as a result of longer hours and broader medical expertise.

Shortfall Reported

A recent survey of physician groups and other provider organizations found that the median amount of estimated future capital needed to build emerging health care organizations in the next three to five years was $1.5 million per respondent. Yet, the median amount of capital these physician groups and other providers had was only $95,000, the survey shows.

The second annual report of the *Capital Survey of Emerging Healthcare Organizations* was conducted by the *Integrated Healthcare Report*, a newsletter in Arrowhead, Calif.; Medical Group Management Association, in Englewood, Colo.; and Ziegler Securities, in Los Angeles.

The results, which are based on 1995 data, show how much money physicians and their provider organizations need to compete effectively and they define several of the emerging health care entities being developed. (See "Definitions of Physician Organizations.")

While many physicians are building larger organizations, most remain in smaller groups. A report last year by the AMA showed that only 225,000 physicians, or 33% of the 684,000 physicians in the United States, were practicing in groups of three of more physicians. Of those in groups, 70% were in single-specialty groups, 22% were in multispecialty groups, and 8% were in family or general practice groups. Moreover, only 7% of all physicians are currently affiliated with publicly traded physician practice management companies (PPMCs), according to health analysts at some of the largest investment banking firms that specialize in health care.

Capital Sources

Most capital for the developing health care organizations comes from venture capital, mezzanine capital, and stock in public companies. Generally, smaller and younger companies use venture capital. Many venture capital firms are seeking physician groups that want to go public. Interestingly, many of the venture capital firms in health care are in Nashville, Tenn.

The Nashville Health Care Council reports that during 1995 and 1996, Nashville-area venture capitalists committed more than $300 million toward starting more than 15 health service providers in Nashville. *Edge*, an economic development magazine for the Tennessee Valley, reported in its fall 1996 issue that $4 out of every $10 in venture capital going into health care nationwide in 1995 and 1996 originated in Nashville.

Companies requiring capital from a passive minority partner that has no plans to run the company use mezzanine capital. Public companies, such as Columbia/HCA, PhyCor, and Medpartners, prefer to acquire established integrated groups or large IPAs capable of dominating a market. In most of these companies, physicians will typically own less than 10% of the total value of the company.

Growing Investment

Whatever the source of capital, investment in physician practices is significant and growing. VentureOne, a research firm in San Francisco, predicts that investment in health care currently leads all other investment sectors and will continue to do so for

Capital Needed in Nine Specific Areas

Respondents were asked to report the amount of capital expended in nine categories.

	Number of responses	Median capital needed ($ in thousands)
Organizational and development costs	198	$53
Management information systems (MIS)	103	$105
Fixtures, furnishings, minor medical equipment	84	$50
Major medical and other equipment	26	$100
Buildings	26	$725
Medical practice acquisitions	37	$1,200
Other	13	$30
Operating cash	128	$213
Composite of all responses	178	$280

Sources: *Capital Survey of Emerging Healthcare Organizations; Integrated Healthcare Report*, Arrowhead, Calif.; Medical Group Management Association, Englewood, Colo.; Ziegler Securities, Los Angeles.

Organizational and Future Capital Requirements

(By type of organization in thousands of dollars)

Respondents were asked to report the amount of total capital needed to develop the organization and to estimate the future capital required in nine categories. (The median figure is reported.)

	Organizational capital	Future capital
IPA or PO	$69	$200
Group, or clinic, without walls	$185	$888
Expanding free-standing medical group	$500	$3,450
MSO	$850	$2,500
PHO	$220	$613
Foundation model	$3,050	$15,900
Staff model	$2,375	$8,500

Sources: *Capital Survey of Emerging Healthcare Organizations; Integrated Healthcare Report,* Arrowhead, Calif.; Medical Group Management Association, Englewood, Colo.; Ziegler Securities, Los Angeles.

Survey Respondents

	Number	Percentage
PHO	93	26.6
IPA or PO	81	23.1
MSO	49	14.0
Expanding free-standing medical group	47	13.4
Group, or clinic, without walls	25	7.1
Staff model	16	4.6
Foundation model	15	4.3
Other form of organization	24	6.9
Total	350	100.0

several years. Bear Sterns, an investment banker in New York, predicts that the physician practice management industry will grow by more than 20% annually through 2000.

David Gans, the director of operations for the Medical Group Management Association, in Denver, says that the capital all various physician organizations will need in the next three to five years may exceed $20 billion, which possibly could be more than the capital markets can supply. Given such a limit, physicians should consider finding different capital sources, such as other provider organizations.

Physicians may want to form a partnership with a local hospital or an HMO, for example. The problem with this option is that hospitals and HMOs have been unsuccessful in managing physician practices. Bear Sterns says in a recent report that when hospitals attempt to run physician networks, they typically run operating deficits of $18,000 to $25,000 per physician per year. In addition, several HMOs, such Aetna, Cigna, and PacifiCare Health System, have recently sold their PPMCs.

Picking a capital partner often involves choosing between a local hospital and a PPMC from out of town. Columbia/HCA has been particularly active in acquiring clinics and in lending them capital. Another potential source of capital is the AMA, which operates the Capital Source Program, a one-year-old initiative designed to link physicians with capital. ■

To order a copy of the report, contract Michele Sedlow, Integrated Healthcare Report, P.O. Box 839, Lake Arrowhead, Calif. 92352-0839, 909/336-1586.

Definitions of Physician Organizations

The *Capital Survey of Emerging Healthcare Organizations* defines several physician organizations as follows:

Independent practice association (IPA), or physicians' organization (PO). This entity is a network of physicians or related providers that contracts with health plans on behalf of its member providers. It also typically administers the contracts on behalf of the network.

Group, or clinic, without walls. This entity is a type of medical group practice that is geographically dispersed and has centralized administrative services. Formed primary to reduce practice costs, a group without walls allows physicians to retain some of their individual practice autonomy by maintaining private offices and individual practice styles.

Expanding free-standing medical group. This entity is a medical group of three or more physicians practicing within a common legal structure that is expanding through hiring or recruiting, merging with, or acquiring small or solo practices. It is also sometimes referred to as a physician equity model because the physicians have an ownership position in the organization.

Management services organization (MSO). This entity provides management services to medical practices and may also purchase tangible assets of medical practices.

Physician hospital organization (PHO). This entity represents both hospitals and physicians and negotiates and administers managed care contracts. The contracts usually involve a sharing of the financial risk of delivering care.

Foundation model. This entity acquires the assets of medical practices and is typically tax-exempt. The medical practices provide professional services to the foundation.

Staff model. This entity involves a hospital or a health plan that employs or contracts with physicians directly.

Source of Capital Affects All Aspects of Physician Group Operations

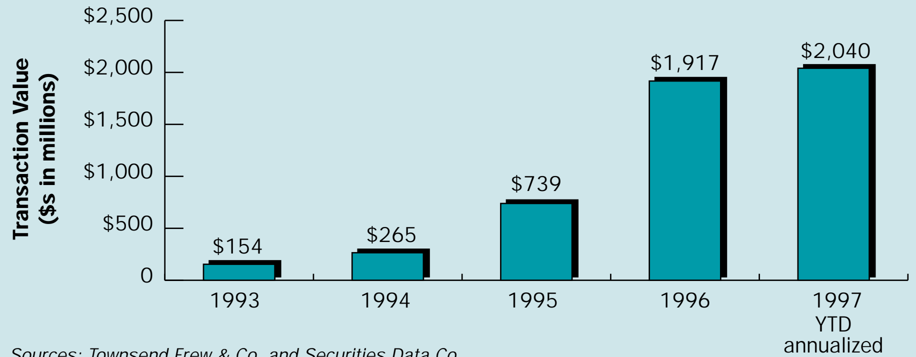
By W.L. Douglas Townsend Jr. and Jill S. Frew

As more physician groups struggle to compete under managed care, they are finding it necessary to raise capital in either public or private markets. The *Capital Survey of Emerging Healthcare Organizations* shows the median estimated future capital requirements for an expanding free-standing medical group is $3.5 million. Such capital would be used to fund information systems, physician network development, and managed care infrastructure. The significant costs of these projects has forced physician groups to seek capital from outside investors and lenders. The recently released survey was conducted by the *Integrated Healthcare Report*, a newsletter in Arrowhead, Calif.; the Medical Group Management Association, in Englewood, Colo.; and Ziegler Securities, in Los Angeles.

Physician groups have several potential sources of capital. Two sources are affiliating with public physician practice management companies (PPMCs) and seeking venture capital. Groups that affiliate with public PPMCs have the opportunity to access the capital PPMCs have procured in the public markets and from banks. Public PPMCs raised nearly $2 billion through equity and debt offerings in 1996, and, on an annualized basis, have filed for or have already raised $2 billion in 1997 (Table 1). Venture capital also is being used widely in health care. In 1996 there were 210 deals completed and these deals raised $1.1 billion for health care companies, more than double the amount raised in 1995 (Table 2).

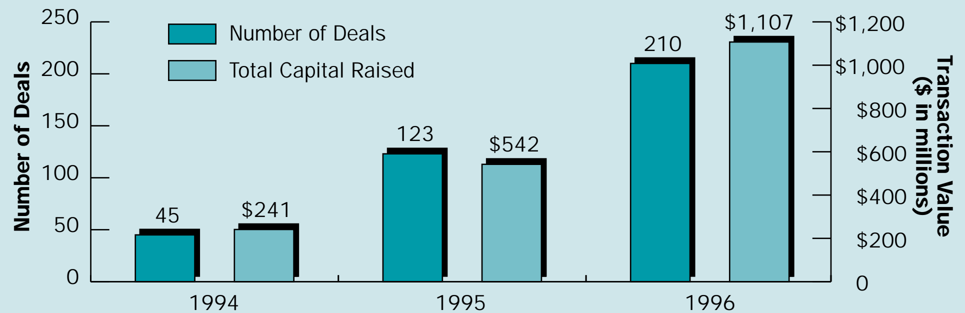
Since the source of capital physicians choose affects all aspects of an organization, it is important to consider the advantages and disadvantages associated with each one and how they fit with the organization's strategic objectives and culture. Table 4 provides an overview of potential sources of capital and the considerations associated with each source. ■

Table 1: Total Capital Raised by Public PPMCs



Sources: Townsend Frew & Co. and Securities Data Co.

Table 2: Health Care Venture Capital Activity



Sources: VentureOne Corp. and Coopers & Lybrand.

Table 3: Venture Capital Investment, 1995 to 1996 ($ in millions)

	Q1 1996	Q1 1995	Growth
Health care	$281.6	$77.9	261%
All sectors	$2,140	$1,170	83%
Health care as percentage of total	13.2%	6.7%	

Sources: VentureOne, San Francisco; *Capital Survey of Emerging Healthcare Organizations; Integrated Healthcare Report*, Arrowhead, Calif.; Medical Group Management Association, Englewood, Colo.; Ziegler Securities, Los Angeles.

W.L. Douglas Townsend Jr. *is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., specializing in health care transactions. He is also a member of the advisory board of* Physician Practice Options. ***Jill S. Frew*** *is managing director of Townsend Frew & Co.*

Table 4: Capital Considerations

Each source or type of capital has advantages and disadvantages. Here are some of the considerations involving each of the most common capital sources:

Senior bank debt

- Relatively low cost; borrowing rate may depend on credit quality of group
- Typically requires pledging assets or personal guarantees
- Restrictive covenants could limit capital expenditures for acquisitions or physician compensation

Variable rate notes

- Relatively low borrowing rate compared with bank debt
- Requires contributions to a sinking fund
- Restrictive covenants can limit capital expenditures
- Refinancing required at maturity

Initial public offering

- Requires historic and projected earnings growth of more than 25% per year
- Significant discipline required to satisfy quarterly earnings and SEC filing requirements
- Typically requires geographical diversity
- Investors demand a 20% to 30% rate of return
- Dilutes physician ownership
- Public currency facilitates ability to acquire other physician groups and raise capital

Venture capital

- Generally designed for emerging companies with growth prospects of 30% to 50% annually
- Investors may take an active role in governance by having a representative on the board of directors and by being involved in significant capital and strategic decisions
- Investors demand a 30% to 50% rate of return
- Dilutes physician ownership
- Requires increased operating and financial discipline
- May be a short-term option because investors may want to sell or go public within three years
- Can be a resource for finding management talent
- Can help facilitate a public offering

Sale and lease-back with a real estate investment trust

- Can reduce balance sheet debt immediately; potentially increases additional borrowing capacity
- Increased lease expense may be greater than the amount of interest and depreciation eliminated as part of transaction
- Potential tax consequences associated with gain on sale of real estate

Private placement of subordinated debt

- Appropriate if senior bank financing has been exhausted
- Higher borrowing rate
- Repayment subordinated to senior bank debt
- Usually involves an equity component, such as warrants
- Restrictive covenants can limit capital expenditures
- Potential sources include insurers, state funds, trusts, and banks

Strategic partner debt

- Favorable and flexible borrowing terms possible
- Ability to gain additional resources from strategic partner
- Potential conflicts and control issues could limit attractiveness, depending on strategic partner

Strategic partner equity

- Cost of capital depends on value at which equity is issued and the type of security issued
- Dilutes physician ownership
- Ability to gain additional resources from strategic partner
- Longer term required than would be available from other sources
- Potential conflicts due to partner's strategic agenda
- Potential partners include practice management companies, hospitals, and HMOs

Physician Executive Outlines How Specialists Can Thrive

Managed care plans put a premium on primary care at the expense of specialty care. But Sam Ho, MD, vice president of health services for PacifiCare Health System, in Cypress, Calif., says specialists can counteract the forces of managed care by demonstrating their value to health plans. After all, the theory behind managed health care is to deliver value, which plans define as the best care provided at the lowest justifiable price. In "The Evolution of the Specialist, " an article in the January/February issue of the *Healthcare Forum Journal,* published by the Healthcare Forum, a research organization in San Francisco, Ho says specialists have 10 ways to demonstrate value to health plans:

1. Demonstrate clinical excellence. Increasingly, physicians will be judged on the evidence of their clinical skills.
2. Collect quality data. Reputation and trust are no longer sufficient. During negotiations with managed care organizations, specialists who can provide data on improvements in patient functional status will have a significant advantage over those who cannot do so.
3. Accept guidelines. Successful specialists who show evidence that they follow written treatment guidelines will be welcomed by managed care organizations.
4. Align financial incentives. Whenever possible, specialists should design systems that reward team efforts in maintaining or in improving patient health.
5. Use physician groups to your advantage. Groups that have the organizational resources to handle complex cases and to assume the financial risk of delivering care will have a competitive advantage over those that cannot do so.
6. Embrace innovation. Certain specialists should be used for unusual situations, Ho says, such as a hospitalist, a new type of specialist who handles only hospital cases.
7. Maintain strong relationships with primary care physicians. Helping PCPs to understand which referrals are appropriate for which specialties is an example of a way to build such relationships.
8. Respect the tenets of managed care. Being derogatory of a managed health plan or of its procedures is not a recipe for success.
9. Strive for high levels of patient satisfaction.
10. Make judicious use of technology. Most health plans carefully track the excessive use of technology.

Comment: *Specialists also are proving their value by forming single-specialty networks that can do health risk assessment, health promotion, disease management, and outcomes measurement and reporting. Other specialists are forming physician organized delivery systems (PODSs), in which small groups of specialists share the financial risk of delivering care.*

Oxford to Use Specialists as Care Coordinators

Oxford Health Plans Inc., a managed care organization in Norwalk, Conn., will have specialists coordinate the care of patients with chronic conditions, such as heart disease, cancer, and other high-cost diseases. Usually managed care plans have primary care gatekeepers to control access to specialists. Yet, patients find PCP gatekeepers to be one of the most onerous aspects of managed care.

"We've come to the realization that the gatekeeper strategy isn't working," says Stephen F. Wiggins, Oxford's chairman and CEO. "It has its place, but it can't be relied on for expensive medical events." Of the $2.2 billion Oxford spent last year on medical care, some 75% was for specialist care, Wiggins estimates. "We're asking primary care to control all of this," Wiggins says. "It's getting complicated, and it's not something primary care doctors were trained to do." The Oxford plan was announced on March 25.

Several managed care organizations and health plans are offering plans that allow patients access to specialists without a referral from a primary care physician. Two of the largest such groups to do so are United HealthCare, in Minneapolis, the nation's largest MCO, and Blue Shield of California, in San Francisco. United HealthCare has used what it calls the open access model since 1982 in which patients can see a specialist or PCP depending on their needs when seeking care.

Comment: *Keeping patients away from specialists has been overblown as a problem, since about 80% of all patients visit a family practitioner before seeing a specialist anyway, says Lee Newcomer, MD, UHC's chief medical officer.*

Proposed Merger of New York Medical Centers Collapses

Last June, the New York University Medical Center and the Mount Sinai Medical Center announced plans to form one center with 2,300 beds and more than $2 billion in annual revenue. Given that managed care does not place a priority on the high-cost care delivered in academic settings, the merger proposal made good economic sense.

After eight months of debate, however, physicians on both sides have decided they cannot work together and the plan has been scrapped. The physicians could not reconcile the cultural, historical, and structural differences between the two medical schools. Physicians at NYU expected to control the combined medical school, and their attitude was viewed as arrogant by their counterparts at Mount Sinai, according to *The Wall Street Journal.*

Among the most serious failings, the two faculties could not agree on who would hold the title of dean of the combined medical school, and the financial structure of the deal would have put NYU at risk.

Comment: *In general, academic medical centers have failed to understand the realities of managed care and are likely to continue to struggle.*

NEWS AND COMMENTARY

Value of Solo Practices Has Declined

While group practices have been increasing in value, the value of solo practices has dropped about 20% over the past four years, says Trish Anderson, owner of Phoenix Healthcare Consulting, in Manhattan Beach, Calif. Currently, one-person family practices range in value from $80,000 to 120,000; solo internal medicine practices generally are valued at $90,000 to $125,000, and a single-person pediatrics practice may sell for $75,000 to $100,000, Anderson says.

Five years ago, when hospitals were acquiring physician groups in great numbers, some primary care practices were selling for $150,000 to $200,000 per physician. For comparison, group practices sold last year at about 1.3 times annual earnings, according to Townsend Frew & Co., investment bankers in Durham, N.C., that specialize in health care.

The number of solo practitioners is shrinking as more doctors choose to become employees or to join group practices. A recent report by the AMA showed that in 1995, 45.4% of doctors were employed. For comparison, only 25% of physicians were employed in 1983. Also in 1995, 40% of physicians were in solo practice, and 32% were in groups of five or more.

Comment: *The two leading reasons physicians chose to become employees and to form larger groups were the growth of managed care and the rise in the number of practicing physicians. The proportion of physicians with managed care contracts was 83% in 1995, up from 56% in 1986. The increasing numbers of physicians are forcing new doctors into an employee status to avoid the risks of opening a new practice. By 2000, the Pew Commission, a philanthropy in New York, estimates there will be a physician surplus of 165,000.*

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

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

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

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

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

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