

# PHYSICIAN PRACTICE OPTIONS™

July 1997

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## Minnesota Employers Elevate Physicians' Status by Eliminating Middlemen

This year, about 7,000 Minnesota physicians—most of them in Minneapolis-St. Paul—began contracting directly with the Buyers' Health Care Action Group (BHCAG), a coalition of 28 self-insured employers. The health plan, called Choice Plus, eliminates utilization review and makes physicians accountable for costs, quality, and patient satisfaction.

"We're achieving a higher quality of health care by empowering physicians, thus diminishing the feeling many doctors have that they are only clerks in the system," says Dee H. Kemnitz, vice president of employee benefits for The Carlson Cos. Inc. in Minneapolis, a BHCAG member. "We've created an accountable health care plan."

Choice Plus is unusual for several reasons:

- It allows its 125,000 enrollees to choose among 23 networks of physician groups, hospitals, and other providers (called care systems);
- It compensates physicians under a hybrid system that includes elements of capitation and fee-for-service;
- It emphasizes quality measurement and consumer education; and
- It removes managed care companies as the arbitrators of care.

BHCAG's experiment in contracting directly with physicians is being watched closely by employers and employer coalitions nationwide. An innovative and influential group, BHCAG is widely respected for its willingness to try unusual approaches to control costs and to improve quality. Whatever success it achieves, however, is likely to be undercut by critics who claim that Minnesotans have a propensity for teamwork that is uncommon in other, more contentious, markets and thus the Choice Plus model may not work in other areas.

Nonetheless, eliminating managed care middlemen and requiring physicians to be accountable directly for quality measurement and cost control are positive steps, says Mark Wiest, MD, co-medical director of Family HealthServices Minnesota, a group of about 70 family practitioners in Minneapolis that is a Choice Plus care system. "We are held responsible for the quality of care we deliver and the cost of that care in a manner that differs significantly from a managed care system," he says. "We submit the claims target and our performance measures go directly to the patient. That accountability creates better medicine." BHCAG has retained a managed care company, HealthPartners of Minneapolis, to provide administrative ser-

vices only, such as enrollment, claims payment, member services, and certain plan-wide integration services.

"Managed care plans can have an important role to play," says Steve Wetzell, BHCAG's executive director of policy and public affairs. "They have the infrastructure to handle administrative functions, but we believe providers—not third parties—should be responsible for monitoring the cost-effectiveness and quality of the care being delivered."

Provider Participation

BHCAG defines family practitioners, pediatricians, and internists as primary care physicians, although a care system also may define

(Continued on page 5)

### CONTENTS

#### Features

**Commentary**  
Like Other Specialists,  
Cardiologists Find Value  
in Practice Management  
Companies 3

**Interview**  
Why Management Service  
Organizations Make Sense  
for Physician Groups 10

#### Departments

**Editorial**  
Tackle the Hard Issues  
Early When Forming an  
Integrated Delivery System 2

**Practice Management**  
The Emerging Role of the  
Inpatient Manager 9

**Capital Ideas**  
Market for Practice  
Management Companies  
Is Turbulent, But Also  
Potentially Attractive 13

**News & Commentary** 15

## Tackle the Hard Issues Early When Forming an IDS

As a physician, chances are that you are affiliated with an integrated delivery system (IDS) of some form—a physician-hospital organization (PHO), a management service organization, a physician practice management company (PPMC), a medical group, or an independent practice association that contracts with an IDS. Regardless of the form of the IDS, or the level of the physicians' involvement in it, participants need to take steps to ensure that their vision for an ideal health care system is adopted.

In doing so, several issues must be addressed early in the development of the IDS, says Peter Kongstvedt, MD, a partner with Ernst & Young in Washington, D.C., and a member of the editorial Advisory Board of *Physician Practice Options*. In *Ten Critical Success Factors for Integrated Delivery Systems* (Aspen Publishers, Gaithersburg, Md., 1996), Kongstvedt says physicians must first define the vision and goals of the IDS and the role of each participating organization in fulfilling those goals. Typically, an IDS includes a hospital, a medical group, an HMO, a PPMC, or some combination of these entities.

Other issues to be addressed in developing the IDS involve organizational control, money, job security, patient referrals, and geographical expansion. Who will control the new organization is an issue that could be contentious and must be decided early. Other control factors to be addressed include: Who will sit on the board of directors? Who controls the money?

Money is obviously an important issue. When forming an IDS, physicians should expect to receive (or must develop) a business plan that includes income and expense targets. Since the IDS will need capital to cover any losses and to build the necessary infrastructure, it may compromise physicians' income. Physicians would be well advised to state up-front and clearly how much income they're willing to sacrifice.

Job security is certain to raise concern among physicians. After all, an IDS is developed to streamline operations, which may result in a loss of jobs.

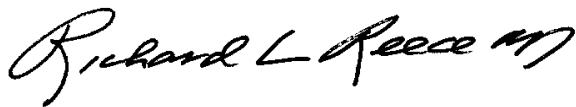
"Turf" wars over the patient base can be avoided if this issue is addressed early. Because most organizations participating in an IDS do so to preserve their current patient base or to capture a competitor's patients, it is likely that participants would clash over patients. A medical group and a hospital in the same IDS, for example, may argue over patient referrals because the group wants to establish extended hours in primary care clinics which could take business away from the hospital's emergency room.

Another issue involves serving particular geographic regions. When participants in an IDS want to expand into new areas, the question arises: Should physicians provide these services independently through their physician group or should they shuttle all patients through the IDS?

Similarly, participants in an IDS may have a specific project they wish to preserve, such as a teaching program, a research project, or a clinic in an underserved area. If so, are these programs acceptable to all and do all participants share the values behind these programs?

Quality-of-care issues also must be addressed. Are participants willing to work with clinical guidelines, severity of illness measurements, and provider profiling systems?

If the parties forming the IDS hammer out a consensus early in the development stages, the likelihood of success—in terms of capital growth and quality of health care—is enhanced dramatically.



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# Like Other Specialists, Cardiologists Find Value in Practice Management Companies

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

Specialists are finding that they need to accept risk-sharing contracts with payers to protect their income and to be able to negotiate from a position of strength. One way to do so is to affiliate with a physician practice management company (PPMC) for the expertise needed to profit under managed care contracts.

"PPMCs are a fairly new concept for specialists, especially those in single-specialty rather than multispecialty groups," says William J. (Terry) Kane, MD, president of InteCardia, a PPMC in Chapel Hill, N.C., that began marketing its services to cardiologists last fall. "PPMCs have been serving occupational medicine and oncology for about two years, but now nearly all the specialties that are a sizable factor in health care are beginning to look at PPMCs, including orthopedics, ophthalmology, and ob-gyns."

Specialists are examining many practice management options because, like other physicians, their revenue is falling as more patients enroll in managed care plans. "It is beginning to dawn on these doctors that the status quo won't work," says Kane. "To survive today, specialists have had to lower their fees continuously under discounted fee-for-service arrangements. They are starting to understand that they can protect their income only by dealing aggressively with managed care—by accepting risk-sharing contracts," he says.

For cardiologists, in particular, PPMCs are still a new concept, Kane says. "But the idea is starting to take hold," he adds. One reason cardiologists may be turning to PPMCs is that being a member of a large multispecialty group can have economic disadvantages.

Walter Unger of Walter Unger & Associates, health care consultants in Laguna Niguel, Calif., says, "Multispecialty groups often have complex compensation distribution structures, in which some specialists are compensated at lower rates than others based on managed care fee schedules and other factors. Cardiologists generally

perceive they are better off financially in single-specialty groups, but even single-specialty groups are becoming vastly more complex to administer."

Specialty PPMCs offer many advantages. For example, in risk-sharing or capitated contracts, physicians accept a set monthly fee for each participant in a health plan. Such arrangements mean physicians are at financial risk for any costs over the given rate and profit only if costs are lower than what they receive in a fee. Determining a capitated fee that produces profits can be complicated, requiring expertise in medical, contract, resource, and information management, all services offered by PPMCs.

About 8% of 527,000 practicing physicians have affiliated with some 30 PPMCs, according to *BusinessWeek* magazine ("Physician Practice Management Groups are Revolutionizing Health Care," March 24, 1997). Most of those physicians are primary care providers, but an increasing num-

ber of medical specialists appear to be affiliating with PPMCs.

## Cardiologists Carve a Niche

"I don't think anyone knows how many cardiologists are turning to PPMCs," says Unger. "But such relationships are of value to cardiologists, just as they are of value to primary care physicians. The most compelling reason is that PPMCs have the ability to deal successfully and efficiently with the costs of practicing medicine that are increasing as a ratio of net revenue collections."

Just forming or joining a specialist group isn't enough to survive financially, however. "Size by itself does not assure success. In fact, very large groups may not be able to capture sufficient market share to support all of the cardiologists. The keys are access, capital, and both managed care and disease management expertise," Kane says.

The American College of Cardiology (ACC) in Bethesda, Md., says in the May

## Market Forces Are Squeezing Cardiologists' Revenue

William J. (Terry) Kane, MD, president of InteCardia, a physician practice management company (PPMC) in Chapel Hill, N.C., says several market trends are affecting cardiologists' practices and income:

- Primarily, cardiologists are doing fee-for-service contracting. Fees are declining and will continue to do so as payers take advantage of the oversupply of cardiologists. Fee-for-service contracting will become untenable.
- The effect of much lower fees will continue to be compounded by declining utilization rates under managed care. Nonexclusive contracting by HMOs prevents cardiologists from gaining an increasing volume of patients to offset declines in utilization and fees.
- Increased managed care penetration will result in lower professional capitation rates.
- To maintain revenue under capitation, cardiologists must increase the number of covered lives they have under contract and they need to develop utilization skills to contain costs while improving the quality of care they deliver.
- To sustain income in this environment, cardiologists need to assume full-risk capitation and develop the skills to manage risk and share in the savings generated from risk-pool arrangements.

issue of its newsletter *Cardiology* that PPMCs “have the potential to offer cardiovascular specialists and other physicians relief from the administrative aspects of practice and the opportunity to obtain the expertise and resources to respond to the demands of managed care.” The college has 21,000 members. Later in the same article, “Physician Practice Management Companies: Opportunities for Cardiovascular Specialists,” the newsletter says, “By combining separate physician’s practices into a single, integrated corporate entity, these organizations allow clinicians to meet managed care organizations and other health care entities on a level playing field. At the same time, by including physicians as

partners, they help preserve clinical autonomy.” In addition, PPMCs allow for the collection of data to improve the quality of patient care and to enhance physician efficiency and productivity, the newsletter says.

PPMCs offer cardiologists capital to invest in the infrastructure needed to be competitive, such as information systems, office expansion or improvements, equipment, and additional staff. “Cardiology is a capital intensive specialty and individual groups may not be able to justify the information systems and ancillary equipment necessary to compete in the future. A PPMC can allocate these costs over several practices,” says Kane.

In *Cardiology*, Harold Karpman, MD, a cardiologist in Beverly Hills, Calif., says, “PPMCs are a vehicle for doctors to become proactive rather than reactive in the managed care environment. These organizations offer physicians the support, in terms of resources and capital, for stabilizing and growing their practices and for approaching managed care payers from a position of strength rather than weakness.”

PPMCs increase efficiencies and help physicians extend their marketing reach. Says Unger, “Marketing to third-party payers is a complex matter, and PPMCs do it more efficiently than groups on their own, let alone solo practitioners. In fact, in all areas where scales of economies exist, there is a decided advantage to PPMC relationships for cardiologists and other specialists.”

Since an oversupply exists among cardiologists and other specialists, it’s a buyers’ market. Therefore, physicians need to be competitive and efficient. “There are too many cardiologists practicing medicine, and they are going to have to learn to be aggressive in grabbing their share of the market. It’s a zero sum game. Increased patient volume will have to come at the expense of other cardiologists,” Kane says. When establishing a PPMC, InteCardia seeks groups of cardiologists in markets of about one million population and 10 to 15 physicians practicing in three or four locations.

#### Setting Standards

When InteCardia finds a cardiology group that meets its criteria, it purchases the practice’s assets and assumes all overhead expenses. The physicians’ corporation remains intact, and the physicians do not

become employees. “This is pretty much standard for the industry,” Kane says. “Our idea is to allow physicians to maintain their clinical autonomy.” InteCardia takes a 15% to 20% management fee annually. “The physicians will experience an initial drop in income, but they will make that up through increased efficiencies,” he says. (See *Capital Ideas*, June.)

Despite the advantages, some experts see a downside to PPMCs. InteCardia and other PPMCs sign 40-year contracts with the groups they manage. “Terminating the relationship prior to its scheduled expiration typically involves penalties, and may involve legal claims,” the ACC says in the May issue of *Cardiology*. Besides penalties and legal claims, the length of the contract can pose a risk to physician autonomy, says the ACC. “Because PPMCs assume the administrative aspects of practice, affiliated physicians no longer have complete control in matters such as office staffing, supplies, and management. Although physicians are generally free to manage patient care as they see fit, PPMC membership involves some oversight of physician practice patterns by the organization’s medical leadership. Thus, in some models, there may be an erosion of clinical autonomy,” the ACC says.

The increase in efficiency from a PPMC relationship and the resulting possibility of a greater financial return compensate for some loss of autonomy, Kane says. “Contracting with anyone has uncertainties, but the services PPMCs offer are critical to surviving in a managed care competitive environment,” he says. Those services include practice management, contracting, and provider management, among others.

Among these services, the one that offers the most value may be disease management, or managing a particular disease intensively. It differs from large case management in that it encompasses all settings of care and emphasizes prevention and maintenance. InteCardia was started in 1995 as a disease management company, named Cardiovascular Outcome Management. The company changed its name to InteCardia in October. “Disease management is a critical element in controlling costs under capitation,” Kane says. “And the only way for cardiologists to protect their income today is to go full risk and enter into capitation contracts, and then be rewarded for the savings they produce.” ■

### PPMC Services

Typically, physician practice management companies offer the following services:

#### Practice Management

- Billing and collections
- Employment of nonbillable staff
- Administration
- Group purchasing

#### Contract Management With HMOs

- For direct contracting
- For capitation

#### Provider Management

- For IPAs, hospitals, and others
- Credentialing
- Financial incentives
- Reimbursement
- Performance management

#### Capital Resource Management

- Business plan development
- Capital availability
- Asset liquidity

#### Information Systems

- Clinical and financial reporting
- Episode of care reporting
- Large data bases linking providers
- Computerized patient records

#### Medical Management

- Clinical protocols
- Disease management
- Quality assurance
- Continuous quality improvement
- Continuing education

## COVER STORY

(Continued from page 1)

ob-gyns as primary care providers. Specialists, allied professionals, and hospitals may participate in multiple-care systems. But primary care physicians may participate in only one care system. "This is a critical element of our plan," Wetzell says. "It creates true provider accountability."

Some providers agree with Wetzell. "Without that requirement, we'd be in the same boat as we were in under the managed care system," says James Reinertsen, MD, CEO of HealthSystem Minnesota, a Choice Plus care system. "Under that system, primary care physicians joined every plan they could, and it was impossible for consumers to determine which providers were performing well and which weren't. Now, when the providers deliver performance data, it is clear which ones are performing well and which are not. That degree of accurate consumer education is critical to cost control, because it will allow for the patient volume that keeps costs down."

In many ways, Choice Plus enhances the patient-doctor relationship, Reinertsen believes. "It is a solid, basic idea," he explains. "If you lose a patient, you know it's because of a problem between you and the patient, it's not because a managed care plan told the patient to go somewhere else. It makes for good therapy."

Under Choice Plus, employees select systems based not only on costs, but also on locations, the doctors included in each system, and performance measures, such as patient satisfaction surveys. Their monthly contribution to their employers' health care premium is determined by which care system they choose. The care systems are divided into three tiers by required contributions.

Although the benefits are the same for all BHCAG companies, employee contributions vary because each company sets its own contribution rate for workers' health benefits. In general, a \$10 difference exists among the three tiers. A worker may choose a more expensive system for convenience or because the employee is familiar with a participating physician. At Dayton Hudson, for example, a nonsmoking employee's contribution for a low-tier care system—one with claims targets or charges to Choice Plus that are comparatively low—is \$30.76 a month; the mid-tier contribution is \$40.60 a month; and the high-tier choice is \$53.66. At other companies, such as 3M, in St. Paul, the contributions are lower because 3M may pay a greater percentage of its workers' health care costs.

"For the first time in this health care market, the relative costs of providers and their affiliated care systems will be visible to employees and will affect their out-of-pocket premiums," Wetzell says. "The visibility of cost differences among care systems is key to this new model. We expect the market will be driven by consumer values, including the level of quality or service for which consumers are willing to pay."

### Choosing Care Systems

Benefit plans among the BHCAG employers are identical, meaning they contain the same menu of services, including mental health and substance abuse treatment, says Kemnitz. "That's a key element of why we believe this plan will be successful," she says. "The care systems knew exactly what they had to offer when they created their claims targets." Claims targets were the basis for the bids submitted to the coalition in the Choice Plus request for proposal last year. BHCAG will use the claims targets as a performance

(Continued on page 6)

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measure to determine compensation rates.

Choice Plus has been a BHCAG health plan option since 1993. Until this year, it was a self-insured managed care plan, structured around a large network of primary care physicians, hospitals, and other health care providers organized by managed care organizations, primarily HealthPartners. Some companies offered Choice Plus as their exclusive health benefits program. Others offered employees a choice between Choice Plus and one or more other managed care or indemnity plans.

Early last year, BHCAG announced “the next step in the evolution of its health care purchasing strategy,” says Wetzell. Choice Plus is a consumer-choice model, he says, meaning members choose among care systems based on the systems’ costs, which providers they want, and the care systems’ performance in areas of quality and customer service. Under the new version of Choice Plus, the employers introduced several important changes to the market, including direct contracting with multiple

care systems, better consumer information, and varied premiums based on care systems’ claims targets.

“BHCAG changed its buying model to create a market more directly driven by consumers and by provider responses to

tracting directly eliminates the middlemen and therefore affords employers more control over health care costs and quality, says Fred Hamacher, vice president for compensation and benefits at BHCAG member Dayton Hudson, a large retailer in

**“If you lose a patient, you know it’s because of a problem between you and the patient, it’s not because a managed care plan told the patient to go somewhere else. It makes for good therapy.”**

**—James Reinertsen, MD, HealthSystem Minnesota**

consumer needs,” Wetzell says. “By taking managed care companies out of the middle of the plan, consumers and providers have more power.”

Employers generally rely on indemnity insurers and on managed care organizations to contract with hospitals, physicians, and physician groups to provide health care to workers, retirees, and dependents. But con-

Minneapolis. In the Twin Cities, enrollment in managed care plans exceeds 80%, says Hamacher, and the national average is about 50%. Since BHCAG was started in 1988, members have had health care cost increases that have averaged about half of that reported by employers nationwide. But by contracting directly, Hamacher believes cost increases can be lowered further still.

## Consumers Get Help When Choosing Among Physicians

To help consumers select a care system, each year the Buyers’ Health Care Action Group (BHCAG) will provide all employees enrolled in Choice Plus with information comparing the attributes and performance of all care systems. BHCAG will rely heavily on patient surveys to develop information consumers can use this year to select a care system for 1998, says Steve Wetzell, BHCAG’s executive director of policy and public affairs, although not all types of information will be available to Choice Plus members in 1997 because data on some quality measurements, such as the number of mammograms performed by a care system, take more than a year to gather.

Annual consumer information will compare the cost of care systems (based on bid claims targets) and performance involving a number of quality and service measurements.

Ultimately, consumers will have access to three types of information:

1. Descriptive information on the care system and on the particular clinics within each care system (including location, hours, and services available); information on individual physicians (including training, certification, statements of philosophy, and languages spoken); and information on specialist referral and hospital relationships;
2. Comparisons of quality at the care system level (including clinical measures of technical quality and patient-reported measures of quality); and
3. Comparisons of customer service and satisfaction among care systems. These comparisons will be made from results of patient surveys addressing such factors as accessibility, ease of seeing the doctor of one’s choice, waiting times for appointments and in the waiting rooms, and staff courtesy.

The consumer information is presented on touch-screen kiosks at member companies, in an abbreviated paper version, and through the Internet at [www.consumerchoice.com](http://www.consumerchoice.com).

### Performance Measurement

Like all employers, BHCAG members are concerned about costs. But when reviewing proposals last year, BHCAG first evaluated all of the more than 100 care systems that responded to its request for proposal on their ability to meet their own performance measurement goals, says Patricia Drury, BHCAG’s director of quality measurement and consumer information. It wasn’t until BHCAG had identified the plans with the most effective quality measurement programs that it began negotiations over price, Drury says. Few—if any—employers choose providers based on quality initiatives before discussing price.

“We required all of the bidders to demonstrate evidence that they had a formal continuous quality improvement plan in place before we even considered pricing,” Drury says. Each of the care systems submitted five performance measures of their own choosing and demonstrated their ability to report on those measures. “We have designed the plan to assure consumers that only providers that meet quality standards be allowed to participate,” Drury says.

To ensure compliance, BHCAG will audit every care system’s quality improvement programs once every three years. The coalition

also is considering hiring an auditor to conduct quality assurance reviews on professional training and to ensure that each care system maintains active and effective preventive-care and treatment-monitoring programs for plan participants with chronic diseases. The information that comes from these audits will be reported to consumers, Drury says. "Consumer education is critical to our plan," she explains. "We believe it is the key to effective health care." Consumers with information about the types of services and quality of care being delivered by specific care systems will make sensible health care choices, Drury says, and allow the market to determine the most effective providers.

### Risk Adjustment

Alan Baumgarten, a Minneapolis health care consultant and author of the annual *Minnesota Managed Care Review*, describes Choice Plus as a "farmer's market direct-contracting model with a unique payment system." BHCAG calls its compensation system a "risk-adjusted, budget-based, fee-for-service schedule," designed to stimulate cost containment and eliminate incentives to choose only healthy enrollees. Each of the plan's 23 care systems bid a claims target on a per-member per-month (pmpm) basis. The bid assumed a standard set of benefits and was based on a utilization history that reflected the entire BHCAG population. The claims target covered about 85 cents of each coalition health dollar; the remainder is spent on administration, specialized services, and out-of-area care.

A care system may have looked at its cost of providing care, for example, and in its bid to Choice Plus projected a claims target of \$100 pmpm. After open enrollment season ended, the population of BHCAG enrollees in each care system is periodically graded by Choice Plus on its actual risk profile (that is, the health care utilization pattern of the population enrolled in that system), and claims targets are adjusted accordingly. If the care system had a higher-than-average risk, its claims target might be raised to \$105 pmpm.

That target is compared with actual claims. If actual claims amounted to \$97 pmpm, for instance, the care system would be rewarded with an increase in the fees its doctors are paid. However, if claims totaled \$110 pmpm, the care system would be penalized and would receive a propor-

## Buyers Ask Physicians to Focus on Quality Improvement

The quality improvement programs in place at each care system are a primary concern to all members of the Buyers' Health Care Action Group (BHCAG), says Patricia Drury, BHCAG's director of quality measurement and consumer information. "We will be continuously monitoring the plans to be certain they have continuous quality improvement programs in place," she says. To qualify for continued participation in BHCAG's health care plan, called Choice Plus, the care systems and their participating providers must meet an extensive set of standards, Drury says.

These requirements fall into the following general categories:

- Quality control and quality improvement programs,
- Access standards,
- Professional credentialing,
- Facilities accreditation,
- Managed care support infrastructure,
- Compliance with rules requiring disclosure of standard performance measures,
- Compliance with case management requirements,
- Electronic claims submission,
- Standard claims formatting, and
- Cooperation with periodic contract and quality compliance audits by an independent party, including review of each care system's quality assurance and quality improvement program.

## System Establishes Aligned Incentives

Officials for the Buyers' Health Care Action Group (BHCAG) say the success or failure of Choice Plus, or any health plan that contracts directly with providers, depends largely on what BHCAG executives call "clearly aligned incentives for consumers, providers, and BHCAG member employers."

Without clearly stated and specific goals, goals everyone shares and understands, a health plan such as Choice Plus can't succeed, says BHCAG's Steve Wetzell. BHCAG set the following objectives for Choice Plus, and asks physicians to reflect these goals in their quality measurement programs:

- Make the consumer the most important customer in the health care market;
- Empower employees, retirees, and their families to choose care systems based on what is important to them, issues such as locations and hours of availability, appointment scheduling, and treatment effectiveness;
- Create more choices and long-term stability for consumers;
- Create a self-insured health plan that will support continuous quality improvement by rewarding high-quality, high-service, cost-effective care systems financially and by providing them with increased market share;
- Create provider accountability for quality, service, and cost;
- Stimulate innovation and creativity in the development and management of care systems;
- Create a health care market in which care systems collaborate, when appropriate, to optimize quality, service, and efficiency;
- Limit the intermediary roles of employers and health plans to specific, value-added services, such as care system performance measurement, member enrollment, and claims adjudication; and
- Create competition among potential vendors of value-added services to support care systems.

tional reduction in doctors' fees. Each quarter, BHCAG will make risk adjustments to care system claims targets to account for the differences in the severity of illness in each care system population.

"The goal is to bring actual experience in line with the claims target," Wetzell says. For a standard patient population, if the care system's claims are lower than the claims target, the fee schedule will be higher in the next quarter. If the claims are higher than the target, the fee schedule will be lower. Having the infrastructure, including information systems and personnel, in place to create accurate claims targets can be expensive, which may mean that some providers will be unable to sus-

tain a relationship with Choice Plus, says consultant Baumgarten. "Some will fall by the wayside. But many doctors say it's worth the expense to eliminate the managed care companies, especially in an area like Minnesota, where managed care penetration is more than 80%. When managed care companies have that degree of market clout, they can set rates pretty much wherever they want to."

All BHCAG employers are self-insured, and therefore subject to regulations under the federal Employee Retirement Income Security Act. ERISA restricts an employer's ability to pass risk to providers. As self-insured employers, BHCAG members will not be able to recover excess claims paid to

care systems that exceed claims targets. Also, unlike a capitated system, the money cannot be collected and pooled; claims must be paid when they are submitted.

"We view Choice Plus as an incentive-based, not risk-based, system because the self-insured employers sustain the risk," says Tom Luchi, chief operating and financial officer for Family HealthServices Minnesota. "We are being paid for the services we deliver whether or not we hit our targets, but the incentive is to spend what we need to spend on infrastructure in order to have the information necessary to sustain our fee schedule. Because Minnesota is so managed care saturated, we already have most of that infrastructure in place." ■

## Two Physician Groups Merge to Meet Direct Contracting Requirements

Seeking to meet the request for proposal sent out by the Buyers' Health Care Action Group (BHCAG), two groups of family practitioners in Minneapolis merged their services last year. By signing a joint operating agreement, physicians in both practices created Family HealthServices Minnesota (FHSM) to take advantage of economies of scale and to respond more effectively to the request for proposal to contract directly with BHCAG member employers, says Tom Luchi, the chief operating and financial officer of the new group.

FHSM includes 46 physicians from MinnHealth Family Physicians and 26 physicians from East Metro Family Practice, both in Minneapolis. By joining forces, the larger group could bid a somewhat lower claims target because it lowered overall operating costs, Luchi explains.

"But the main incentive was that together we could provide an even higher quality of care," Luchi says. "We may have done this anyway, but the BHCAG bid was certainly an incentive." Although the two groups created a single entity to provide scheduling, billing, and other administrative services, they did not merge financial assets.

"By not merging our assets, by not becoming a single incorporated entity, our physicians remain independent," says

Luchi. Such independence is important "because MinnHealth and East Metro continue to have the same compensation and profit-sharing arrangements with their doctors that they've always had, and the doctors continue to work for and with the doctors they originally went into business with and with whom they are comfortable." By merging the operational end of the practices, the two groups reduced overall expenses by \$175,000 in the first year alone, Luchi says. The combined practices had operating revenue of \$35 million last year from 15 clinics covering 40 square miles and provided services to about 5,000 Choice Plus beneficiaries.

"In essence, we became too large for BHCAG to ignore," says Mark Wiest, MD, FHSM's medical co-director.

In its request for proposal last year, BHCAG focused closely on quality measurement and continuous quality improvement programs. "Both MinnHealth and East Metro had quality measurement programs in place before the joint agreement," says Luchi. "But our proposal to BHCAG stressed that by combining our operations we could create an enhanced continuous quality improvement program because we could learn from each other's programs and experiments."

Among several quality improvement pro-

grams, the combined operations have standardized the scheduling of well-child care, which involves regular checkups and immunizations for newborns and toddlers. FHSM developed administrative tools, such as periodic mailings for parents and tickler files for physicians, which remind staff of the need to schedule physicals and other visits.

FHSM also assigned a task force to standardize procedures for scheduling appointments among all clinics. The task force determined that appointment time should be defined as the time a patient should arrive at a clinic rather than the time a patient would see a doctor. This change afforded scheduling staff a better understanding of how far apart appointments should be set so that they could provide patients with a reliable estimate of how much time they might have to wait. Not surprisingly, when patients spend a lot of time waiting past scheduled appointment times, patient satisfaction scores decline.

Moreover, FHSM developed a program to increase the immunization rate of children on the east side of Minneapolis. "In response to concerns that immunizations were less than 50% on the east side, the group initiated an education and outreach campaign to improve the immunization rate, which is now better at 95%," Luchi says.

# The Emerging Role of the Inpatient Manager

By Louis Roddy, MD, and Philip A. Sanger, MD

Physicians have protested loudly about the financial constraints managed care organizations have placed on them and their patients. In fact, many physicians argue that cost containment means quality containment. Fortunately, outcomes do not support these fears. Patient satisfaction rates are stable, readmission rates are no greater than in the fee-for-service sector, and physician reimbursement is relatively high.

Two groups of physicians have emerged from this environment. The first group consists of the influential primary care gatekeepers, who dictate care and refer patients with complex problems to subspecialists, if necessary. But increasingly, primary care physicians (PCPs) have become outpatient specialists—the second emerging group. The role of the inpatient physician has been assumed by the internist or medical subspecialist. In some areas of the country, this trend has reduced length of stay and improved outcomes. But in some markets, length of stay has soared, hospital complications have increased, and outcomes have worsened, creating the need for inpatient management and the inpatient manager (also known as an intensivist, internist, or hospitalist). “Hospitalists”—a term coined by Robert M. Wachter, MD, and Lee Goldman, MD, professors at the University of California,

in San Francisco, who wrote “The Emerging Role of ‘Hospitalists’ in the American Health Care System,” in *The New England Journal of Medicine*, Aug. 15, 1996—do only hospital care. That targeted role allows them to see patients several times during the day, thereby establishing trust with patients and improving the quality of care. In addition, they can diagnose, treat, and rapidly move patients to the most appropriate level of care. As a result, lengths of stay and concomitant in-hospital morbidity have declined in hospitals that have these inpatient managers

## Market Advantages

Using a hospitalist appropriately can provide big competitive advantages for a physician group. In managed care markets where payers pay per-diem rates to hospitals, decreasing the number of days allows some funds to be available for other needs, such as physician revenue. In a traditional setting—where hospitals are at risk for the cost of expensive and prolonged hospital stays—a hospitalist can decrease length of stay and the number of inappropriate tests ordered, as well as discourage or eliminate the overuse of subspecialists. The result: Hospital administrators are pleased and patient satisfaction is high.

Patients move through the continuum of care much as they have always moved, except more quickly if their care is managed by an inpatient specialist.

Another advantage of an inpatient manager can be found in the emergency department. There, hospitalists can assess patients prior to admission, evaluate those who have been referred by PCPs, and assist in surgical cases as needed. Since hospitalists are on site for most of the day and night, they can help to improve patient care overall. Laboratory data and ancillary testing, for example, can be completed and reviewed more quickly than in a traditional setting.

Critics might argue that using an inpatient manager results in a lack of continuity of care. That argument stems from the fact that in most settings, the PCP follows the patient from the office, to the hospital,

and back to the office. Yet, this system forces PCPs to squeeze rounds into early morning or late evening hours to save time for the increasing demands of outpatient care. As a result, laboratory and other hospital data are not evaluated in real time, causing length of stay to increase. Prolonged length of stay often predisposes patients to complications.

When PCPs have concluded that they can be of more value in the office and have thus delegated in-hospital care to an inpatient manager, the patient, the hospital, and the insurer get a designated outpatient specialist and a competent inpatient specialist.

A question may arise about the role of subspecialists. This model excludes many of them from being the attending physician. It also discourages consults between physicians. Under the inpatient specialist model, a patient with chest pain would not automatically be referred to a cardiologist. Because transient ischemic attacks or minor strokes are often managed by an intensivist without a neurologist's involvement, does this system compromise the quality of care? We think not. Outcomes are improved and unnecessary tests are not being done. Conversely, this system does not preclude the need for subspecialists. A patient with a complicated myocardial infarction needs a cardiologist.

Subspecialists must see these patients in a timely manner and involve the inpatient manager in decisions regarding testing and treatment. In this way, length of stay would not be prolonged and increases in morbidity associated with prolonged length of stay would be avoided.

We believe inpatient management will become a medical specialty. Its evolution will not be unlike that of emergency department physicians. Just as emergency medicine has become a well-respected specialty, we foresee inpatient management medicine will be a specialty in the future. ■

*Louis Roddy, MD, is the director of inpatient management for Inpatient Medical Services, P.A., in Houston. Inpatient Medical Services (IMS) is a physician-owned company that assists physicians, hospitals, and managed care organizations in developing inpatient medical management programs. Board certified in pulmonary medicine, internal medicine, and critical care medicine, Roddy also is national inpatient medical adviser for North American Medical Management, a division of PhyCor, in Nashville, Tenn.*

*Philip A. Sanger, MD, is the CEO of IMS and is board certified in pulmonary medicine, internal medicine, and critical care medicine.*

*Editor's note: For more information on inpatient management, contact IMS at 713/861-0209 or at [www.inpatient-med.com](http://www.inpatient-med.com).*

# Why Management Service Organizations Make Sense for Physician Groups



**Thomas M. Gorey Jr.** is president and CEO of Policy Planning Associates in Crystal Lake, Ill., a health care consulting firm he started in 1992. Prior to starting Policy Planning Associates,

Gorey served on the staff of the American Medical Association for 11 years in a variety of positions, including legislative attorney and director of physician practice services. He also served as executive secretary for the AMA's Council on Long-Range Planning and Development for six years. He holds a law degree from DePaul University College of Law. Recently, Policy Planning Associates completed an analysis of management service organizations (MSOs) for the American Medical Association and several state and specialty medical societies. The 82-page report, *Management Service Organizations: Cases and Analysis*, will be published this summer by Health Administration Press, Chicago. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

**Q.** What is the definition of a management service organization (MSO)?

**A.** In the broadest sense, an MSO provides managed care contract administrative services or practice management services to physicians and medical groups. It can be owned by physicians, hospitals, private investors, or any combination of these entities. In some cases, the MSO purchases the assets of medical practices, in which case the physicians and their office staffs become the employees of the MSO. In other cases, MSOs offer services to networks of physicians, who maintain private, independent practices. In many cases, MSOs are combining these approaches. Recognizing that physician organizations forming throughout the country lack the administrative resources and the management resources to be successful, some medical societies are consid-

ering forming their own MSOs, or at least providing information to their members on MSOs and how they can interact with physicians in solo practice or in groups.

**Q.** What services do MSOs offer?

**A.** Most provide a blend of contract management and practice management services. The contract management services usually include negotiating managed care contracts, credentialing physicians, conducting quality and utilization management, enrolling members, and administering claims. Practice management products and services usually include office management, such as billing and collection, appointment scheduling, and staff recruitment, and practice assessments, group purchasing, information systems, risk management, and physician education.

**Q.** Do physicians need to be in groups to affiliate with an MSO?

**A.** Not necessarily. One interesting finding from our recent study is that there are a number of MSOs providing services in highly competitive markets, such as Southern California, where physicians are continuing to practice in solo settings. Those physicians can thrive in a competitive setting if they are affiliated in some manner with an MSO that can effectively do contracting and other administrative services for them. Many MSOs are implementing a strategy of affiliating with both independent practice associations (IPAs) and medical groups. Their strategy is driven by an uncertainty about which organizational model will survive in a given market. By allowing flexibility, the MSOs give physicians the opportunity to choose the independence, control, and flexibility of an IPA, or the financial security and administrative support offered by membership in a medical group. MSO services are available to both. So physicians don't necessarily need to affiliate with a fully integrated group.

**Q.** Are you saying that IPAs in Southern California have demonstrated that physicians can successfully join loosely orga-

nized groups spread over broad geographic areas and still do well professionally through the use of MSO services?

**A.** Absolutely. Over the last two or three years, there has been some speculation among health care experts that IPAs may not succeed because they are loosely organized and don't have tight control over utilization management and quality management because their physicians are practicing in separate offices. But Southern California IPAs have proven that they are able to manage utilization and quality as effectively as some of the fully integrated groups, where physicians practice under one roof, through the purchase of MSO services and affiliations with MSOs.

**Q.** Are physician practice management companies a type of MSO?

**A.** Yes. There are actually many types of MSOs. MedPartners, a large national publicly traded company in Birmingham, Ala., is an example of a PPMC-type MSO. The Pennsylvania Medical Society in Harrisburg has a small MSO, which has been operational for about two years. There are hospital-owned and hospital-run MSOs. They tend to evolve after a hospital has purchased some medical practices, and they generally provide administrative services only to those practices, although some also are marketing their services to independent physicians.

**Q.** What are some of the issues physician groups should consider in deciding whether to organize their own MSO?

**A.** The most important issue is capitalization. An MSO requires a substantial amount of capital to operate. Initial capitalization requirements can range from \$1 million for small MSOs to hundreds of millions of dollars for MSOs operating in multiple regions or on a national basis. Since operating deficits are common for the first several years of MSO operation, sufficient capital is necessary to cover shortfalls.

One capitalization problem physicians are likely to encounter if they are interested in forming an MSO is that, unlike other busi-

nesses, medical groups do not retain earnings. They do not have ready access to funds that can be used for capitalization. Therefore, many physician-owned MSOs eventually look for financial partners who can invest the millions of dollars it takes to build the necessary infrastructure. In those cases, there's a trade-off of some autonomy for necessary capital, but it can be a wise decision that will allow physicians to retain more autonomy in the long run, more autonomy perhaps than results from being purchased by a hospital.

Other issues that arise when developing an MSO include attracting qualified administrative staff and developing a governance structure that will work well for all members. Physicians should play active roles on MSO boards, on committees, and in administrative positions. At the same time, an MSO must be run as a business, meaning physicians must be willing to grant broad authority to the qualified administrators they hire to make decisions.

**Q.** *What are some of the most important issues in an affiliation or MSO ownership relationship?*

**A.** There are three primary issues. One issue, of course, is physician compensation. Physicians employed by a medical group that is either affiliated with or owned by an

Physicians should examine compensation methods carefully before deciding whether to affiliate with an MSO, or to join a group owned by or has a strong affiliation with an MSO.

sacrificing some short-term compensation to have an equity position in an entity that may ultimately produce some significant financial rewards for the physicians involved. Many physicians also are discov-

**“Physicians are beginning to understand the concept of equity and the fact that it may be worth sacrificing some short-term compensation to have an equity position in an entity that may ultimately produce some significant financial rewards for the physicians involved.”**

A second important issue is the effectiveness of the MSO's contracting efforts. Although MSOs engage in different types of contracting arrangements, their efforts are generally geared toward capitation. Because these contracts are complicated, MSOs can provide an important service to physicians if they have sufficient expertise in capitated contracting. Before making a decision on an MSO relationship, physicians should gather as much information as possible on the number and nature of existing contracts with payers. They should talk to other

ering that through physician organizations linked to an MSO, or one that has capabilities similar to that of an MSO, they can compete effectively with some of the largest players in the national marketplace.

**Q.** *What are the implications for relationships between hospitals and physicians when physician groups affiliate with an MSO?*

**A.** Physician-hospital organizations (PHOs) start out believing there is going to be cooperation between physicians and hospitals. Although the PHO model would seem to encourage that cooperation, it doesn't necessarily happen, often because the PHO is simply imposed on a medical community with no steps taken to improve the relationship between doctors and the hospital.

One of the key findings of our study is that most physician organizations with MSO capabilities in highly saturated managed care markets are taking a cooperative approach toward both hospitals and payers because they recognize that to be successful they need to partner effectively. MSO-affiliated medical groups tend to appreciate the requirements of managed care contracting and therefore negotiate with hospitals from a realistic position because they understand the market, the role of the hospital, and the role of the physician. They are willing to recognize the hospital's right

**“By affiliating with or buying services from MSOs, some IPAs in Southern California have proven they can manage utilization and quality as effectively as some large, fully integrated groups.”**

MSO are usually compensated through some combination of salary and financial incentives. Most MSOs believe it is important to use financial incentives, tied to performance measures, as part of a compensation package. Some MSOs affiliated with IPAs use a capitation compensation model, which ties the physicians to the success or failure of the MSO's fixed-fee managed care contracts. Others compensate on a fee-for-service basis.

providers that have a history with the MSO.

The third important issue involves equity, or profit-sharing based on an investment in the MSO. Traditionally, many physicians have focused exclusively on immediate financial return for the work they do, whether it is from a medical practice or some other affiliation. But many physicians are beginning to understand the concept of equity and the fact that it may be worth

to realize a reasonable financial return, and, in return, expect the hospital to recognize the legitimate role of physicians.

**Q.** *We are experiencing a wave of consolidations in health care, among managed care organizations and providers. Is that happening among MSOs as well?*

**A.** There has been a lot of consolidation among MSOs, especially among

smaller MSOs that may have been successful a few years ago, before the overall market became highly consolidated. Some large national MSOs, such as MedPartners, have developed a strategy of acquiring or affiliating with smaller MSOs because the \$1 million capitalized MSOs are, in many cases, not going to be able to survive long term by remaining independent.

## Steps to Take When Forming or Affiliating With an MSO

When deciding whether to organize or affiliate with a management service organization a provider should consider several issues, says Thomas M. Gorey Jr., president and CEO of Policy Planning Associates, health care consultants in Crystal Lake, Ill. The issues are as follows:

- *Is the MSO adequately capitalized?* Establishing and operating an MSO requires a substantial amount of capital, anywhere from \$1 million to hundreds of millions of dollars.
- *How strong is the MSO's administrative structure?* Administrative support is critical to an MSO's ability to carry out day-to-day operations. To be successful, an MSO must be willing to commit the financial resources necessary to attract and retain qualified, experienced administrative personnel, including a medical director and other physician administrators.
- *Does the MSO have strong physician participation in its governance structure?* Successful MSOs recognize the importance of providing a significant role for physicians when making decisions that affect patient care.
- *Does the MSO work with independent practice associations (IPAs) and medical groups?* Such flexibility can give providers the opportunity to choose the independence of an IPA or the security of a medical group.
- *Does the MSO have effective strategic partnerships?* To be successful, MSOs need to align themselves with strategic partners to help expand market share. Successful MSOs know they must work cooperatively with payers.
- *Does the MSO have effective quality management processes?* Payers expect MSOs to demonstrate that their physicians provide high-quality care, forcing MSOs to collect and report extensive data on quality management. The MSOs also should have a physician-driven quality management committee.
- *What is the MSO's approach to utilization management?* Proper management of utilization is vital to the financial success of an MSO. Therefore, almost all MSOs have or are implementing a medical management program. The medical director should be responsible for utilization management, and a utilization committee should be composed primarily or entirely of physicians or their representatives.
- *How effective are the MSO's contracting efforts?* MSOs can offer an important service to physicians by providing the expertise necessary to enter into capitated, or fixed-fee, managed care contracts.
- *How are physicians compensated?* MSOs often have incentive programs to enhance salary contracts.
- *Does the MSO have adequate information systems?* Since adequate information systems are critical to the success of an MSO, physicians should inquire about an MSO's current system and its plans for future systems, if any. An MSO should be willing to devote significant financial and administrative resources to developing its information system.

But our definition and our vision of what consolidation involves are changing. There are some models emerging now that are essentially umbrella organizations able to handle the administrative and contracting support needs of individual physicians and physician groups, for a fee. It is worth noting that in the flurry of provider consolidation in the last few years, a lot of time and energy went into the organizational phase, to the neglect of the business or the administrative side. In many cases, those organizations underestimated the incredible administrative resources required to be successful as a physician organization or as a PHO, so now they are turning to MSOs.

**Q.** *Are MSOs growing in popularity? If so, is it in response to the managed care market, because managed care organizations prefer to deal with large physician groups or physician networks?*

**A.** MSOs are becoming increasingly popular among physician groups. Part of the reason for the success of these organizations is that physicians have a reasonable amount of involvement and control in a lot of these MSOs. They offer an opportunity for professional autonomy as opposed to looking to an HMO that will impose particular requirements.

Also, MSOs have been effective in involving their physicians in capitation. As a result, physicians have responded well to MSO educational initiatives regarding risk-sharing and to some of the incentives provided by MSOs to manage utilization and quality. Physicians have surprised themselves and others at how effective they can be at managing care.

In addition, one important value MSOs offer is that they can consolidate large numbers of physicians for contracting purposes. Some payers have been reluctant to deal with many PHOs and physician organizations because they don't have the number, or the right mix, or the geographical distribution of physicians to meet the payers' needs. MSOs are successful because they have been able to consolidate larger numbers of physicians. For payers, that means not having to negotiate with a larger number of separate physician organizations or PHOs but being able to negotiate with a centrally located MSO that covers a large region. ■

# Market for Practice Management Companies Is Turbulent, But Potentially Attractive

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

Physician practice management companies (PPMCs) are continuing to raise large amounts of capital in the public markets, even though the market for publicly traded PPMC stocks remains turbulent. This situation should lead investors to evaluate carefully any proposed offerings by PPMCs.

## After-market Performance

In the first quarter of 1997, eight PPMCs completed or filed for initial public offerings (IPOs) and expected to raise \$116 million (Table 3). Six of the eight were single-specialty PPMCs. These offerings often seem successful, at least in the short term, because the majority of such companies have shown an increase in price one week after the offering. Wall Street demonstrates its interest in PPMCs through increased stock prices immediately after an initial public offering.

What happens after more time passes, though, is interesting. Of the 24 companies listed in Table 2, only slightly more than half have continued to show an increase in price since completing their IPOs. Certain characteristics of these companies account for their success in the public markets; among them:

- An ability to hit Wall Street's earnings estimates consistently;
- Strong predictions of future growth, of 20% or more per year;
- Disciplined pursuit of strategic acquisitions in selected specialties and geographic areas;
- Consistent pricing of acquisitions;
- Successful implementation of opera-

- tional efficiencies in acquired clinics;
- Proven ability to integrate affiliated practices into existing operations; and
- Productive relationships with affiliated physicians.

## Postponed Offerings

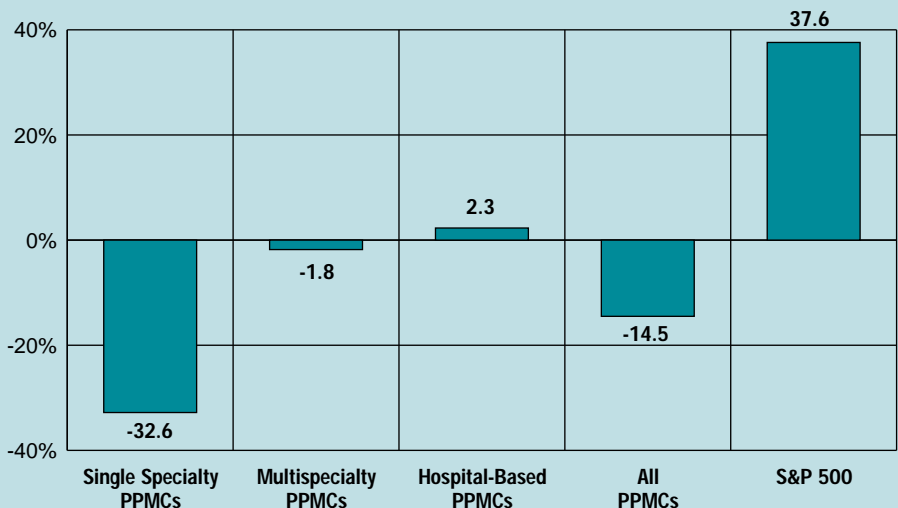
Although individual companies—such as PhyCor Inc., a multispecialty PPMC in Nashville, Tenn.; FPA Medical Management Inc., a multispecialty PPMC in San Diego; and Orthodontic Centers of America Inc., a dental PPMC in Ponte Vedra Beach, Fla.—continue to increase in price, PPMC returns as a whole continue to lag behind the S&P 500 (Table 1). From the beginning of 1996 to May 1997, only shares of hospital-based PPMCs' increased in price and their increase was much less than that of the S&P 500. These market conditions led AmeriPath Inc., a PPMC specializing in pathology in Riviera Beach, Fla., to postpone its IPO, which was scheduled for completion the first week of April. Also, the company cut the number of shares for the IPO from 6.2 million to 4.0 million and the price from \$13 to \$15 per share to \$10 per share.

## Looking Forward

On April 2, Monarch Dental Corp., a dental PPMC in Dallas, filed for an IPO that could raise as much as \$34.5 million for the company before expenses. Monarch plans to use most of the proceeds to repay debt and to redeem preferred stock principally held by TA Associates, a venture capital firm in Boston. On May 6, IntegraMed America Inc., a PPMC in Purchase, N.Y., that operates infertility clinics, filed for a secondary offering that is expected to raise \$8.8 million after expenses. The company will use most of the proceeds to finance its acquisition of Fertility Centers of Illinois, in Northbrook, Ill.

PPMCs continue to attract Wall Street's attention. As more companies make public offerings, investors can become more selective with their investments, requiring PPMCs to differentiate themselves. Furthermore, analysts have raised concern that some PPMCs may be going public before they have a solid operating history or adequate financial controls, hoping to cash in on the market's interest. These companies may find themselves struggling to perform well after completing their offerings. ■

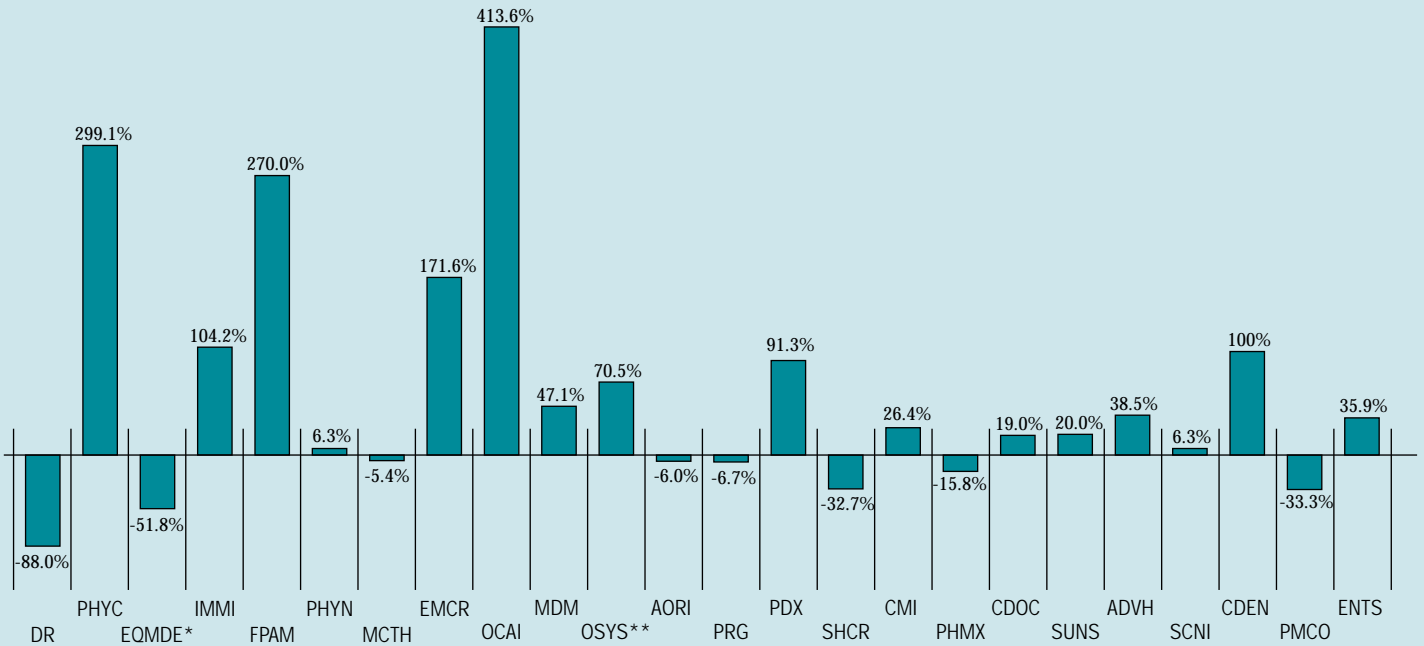
**Table 1: Average Stock Returns** (Jan. 1, 1996 through May 9, 1997)



Source (for all tables): Townsend Frew & Co., Durham, N.C.

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 2: Performance of Selected PPMCs**



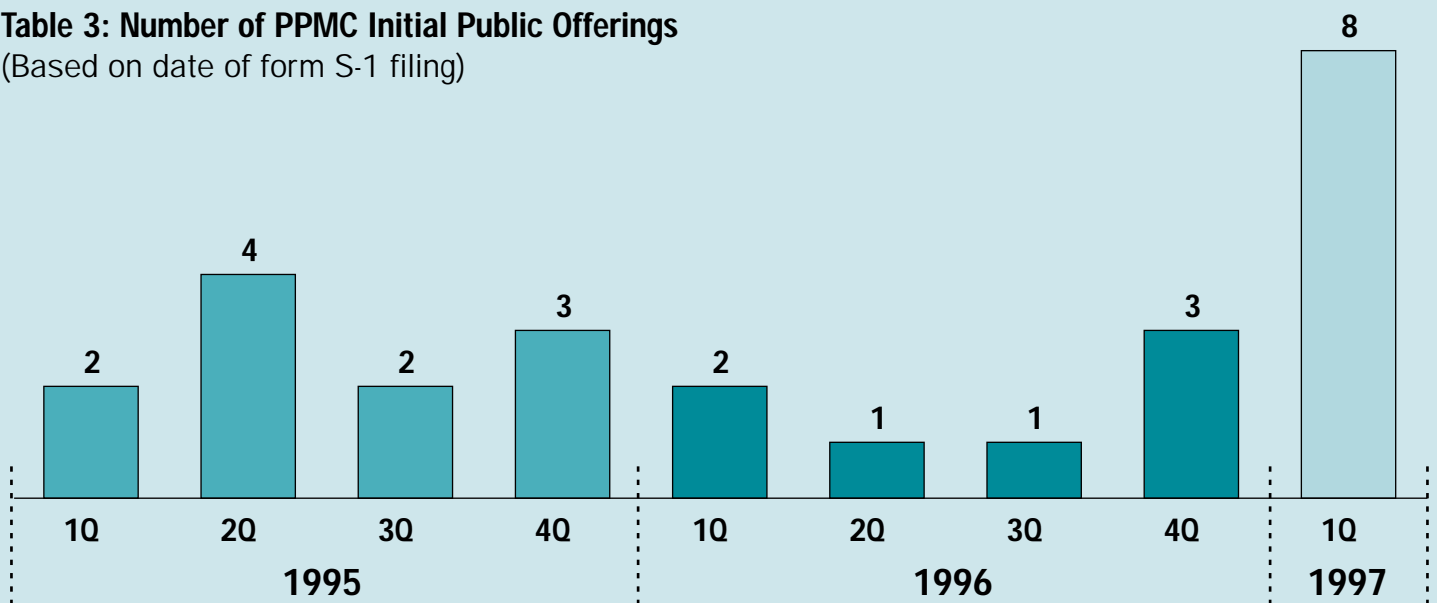
DR	Coastal Physician Group	OCAI	Orthodontic Centers of America	PHMX	PhyMatrix
PHYC	PhyCor	MDM	MedPartners	CDOC	The Company Doctor
EQMDE	EquiMed	OSYS	OccuSystems	SUNS	SunStar Healthcare
IMMI	InPhyNet	AORI	American Oncology Resources	ADVH	Advanced Health
FPAM	FPA Medical Management	PRG	Physician Resource Group	SCNI	Specialty Care Network
PHYN	Physician Reliance Network	PDX	Pediatrix	CDEN	Coast Dental Services
MCTH	MedCath	SHCR	Sheridan Healthcare	PMCO	ProMedCo
EMCR	EmCare	CMI	Complete Management	ENTS	Physicians Specialty Corp.

\* Announced it would be acquired by MedPartners on Jan. 21, 1997.

\*\* Announced it would merge with CRA Managed Care on April 21, 1997.

**Table 3: Number of PPMC Initial Public Offerings**

(Based on date of form S-1 filing)



## FTC Sues Colorado IPA Under Antitrust Rules

The Federal Trade Commission has sued a rural Colorado physicians' group, the first such suit under new antitrust guidelines issued last year, according to *Modern Healthcare*, May 19.

The FTC said Mesa County Physicians IPA had engaged in price fixing and had refused to deal with some payers. The IPA in Grand Junction has 192 physician members, including 85% of the physicians in private practice and 90% of the primary care physicians (PCPs) in the county in remote western Colorado.

The IPA has denied it violated antitrust laws, *Modern Healthcare* said.

Among other issues, the FTC wants the IPA to cut the number of PCPs. The group used newsletters and other documents to encourage physicians not to affiliate with some health plans and the physicians could do so only with the group's approval, the FTC said.

The group has a multiyear contract with Rocky Mountain HMO, in Grand Junction. The HMO's enrollees comprise 50% of the group's patient volume, the FTC said, forming a substantial obstacle for other payers seeking to work with the group's doctors. In fact, county physicians helped start the HMO in the 1970s. The FTC also said the group has a fee schedule it uses when reviewing offers from payers. The fee schedule results in significantly higher prices.

**Comment:** *The group is caught in a Catch-22. To succeed under managed care, physician groups need a strong primary care base. But the government says locking up too many PCPs may create an obstacle to competition.*

## Connecticut Medical Society Launches Management Service Organization

The Connecticut State Medical Society has formed M.D. Advantage, in New Haven, a management services organization (MSO). The MSO gives physicians a range of services, including practice management, information systems, and network development, while allowing them to retain clinical, professional, and business autonomy. The society worked with MED3000 Group Inc., a physician practice management company in Pittsburgh, that has developed and administered successful physician-owned MSOs in several states. The society received capital from Novartis Pharmaceuticals, in Summit, N.J.

"Physicians want control of their prac-

tices and their future, and M.D. Advantage will offer a physician-friendly and physician-directed alternative to the current choices of working with a hospital, a payer, or a commercial management company," says Michael Deren, MD, the society's immediate past president.

**Comment:** *State medical societies have had trouble raising capital from their members to start provider-owned HMOs and MSOs. The Connecticut society avoided this problem by getting capital from other sources. In the 1980s, the society started MD Healthplan, a physician-led HMO in North Haven, Conn., which it sold last year to International Health Systems, now Foundation Health Systems in Rancho Cordova, Calif.*

## University of Pennsylvania to Establish Orthopedic Center

The Penn Musculoskeletal Institute at Pennsylvania Hospital will serve as the home of most orthopedics activity for the University of Pennsylvania Health System's three primary acute-care hospitals: the Hospital of the University of Pennsylvania (HUP), Pennsylvania Hospital, and Presbyterian Medical Center (PMC).

While HUP and PMC will maintain basic services, highly specialized orthopedic care will be moved to Pennsylvania Hospital by September. Such care includes reconstruction and microvascular surgery (including hand surgery), orthopedic oncology, joint reconstruction and replacement, sports medicine, foot and ankle surgery, and diagnosis and treatment of congenital disor-

ders of the back, spine, shoulder, and elbow.

The new Penn Musculoskeletal Institute will be staffed by 20 physician members of the health system faculty and by physicians to be recruited from hospitals nationwide.

**Comment:** *Recognizing that \$125 billion is spent annually on musculoskeletal diseases, the university is moving to establish a specialty business in a substantial field, which encompasses orthopedics, occupational health, rehabilitation, neurology, rheumatology, and sports medicine. Two orthopedic companies—Specialty Care Network in Lakewood, Colo., and Integrated Orthopaedics Inc. in Houston have gone public, and at least four others may follow in 1997.*

## Florida Law Gives Patients Direct Access to Dermatologists

Florida is the second state to allow patients to seek care directly from a dermatologist without a referral from a gatekeeper physician. In 1995, Georgia became the first state to do so when the legislature passed a bill requiring direct access to dermatologists. Dermatologists in Illinois, Indiana, Mississippi, Missouri, Montana, and South Carolina are working to win similar legislative approval, saying direct access reduces costs and is necessary

because any patient can determine the need to see a skin specialist. If treatment is delayed or skin conditions are misdiagnosed, a skin condition such as melanoma could be fatal.

In May, the Florida House and Senate passed the bill requiring direct access and allowing as many as five visits per year without a referral.

**Comment:** *Several states have laws allowing direct access to ob-gyn care, out-of-plan providers, and emergency room visits.*

## NEWS AND COMMENTARY

### Pediatric Management Company Forms Partnership

Kelson Physician Partners Inc., a pediatric practice management company in Bloomfield, Conn., has formed a long-term partnership with Tenaflly Pediatrics, a pediatric practice in Tenaflly, N.J. "In Kelson, we have a strong business and capital partner," says David Wisotsky, MD, managing partner of Tenaflly Pediatrics. The group plans to expand geographically and to build operating infrastructure.

Kelson was established by physicians and managed care executives to provide practice management expertise and investment capital to multispecialty primary care groups, but has decided to focus exclusively on pediatric practices, says Joel S. Kassan, Kelson's vice president, regional business development.

**Comment:** Mark Buchanan, MD, Kelson's vice president for medical affairs, has said the company was concentrating on the Eastern United States with a special emphasis on the Northeast. Physician care in this area is fragmented and the managed care market is relatively immature, he has said.

### Two Health Plans Eliminate Gatekeepers

Humana Inc. in Louisville, Ky., is offering two new programs that let members seek care outside of the closely monitored methods traditional in HMOs. One program lets members seek care from any physician without a referral from a PCP, and the other provides benefits to members using doctors and hospitals outside the provider network. Members who stay in-network get higher benefit levels. Women in plans offered by CIGNA HealthCare, of Hartford, Conn., no longer will need a referral from a PCP for covered ob-gyn services.

**Comment:** Having patients pay more for open access to capitated specialists allows health plans to collect more in fees and pay specialists less.

### 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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