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Market Demands Physicians Find Strength in Numbers

Seeking clinical independence in the current managed-care dominated market, many independent physicians want to move from a position of weakness to one of strength.

Markets are moving quickly toward managed care maturity. In such metropolitan areas as Atlanta, Miami, New Orleans, Denver, Philadelphia, and New York, rapid transformation to managed care has occurred within 18 months, creating chaos in some places.

Some markets have doubled in maturity within two years and the rate of acceleration increases as markets mature. (See Table 1: Estimated Market Maturity.) Even a slight shift in a single year can be accompanied by significant turbulence. Hospitals close or merge, hospital employees are laid off, hospital unions stage protests, and hospitals or medical groups are bought by for-profit companies. Among other characteristics of a market in turmoil are these: specialists are excluded from networks, hospitals and physicians form networks, hospital systems buy physician practices, academic centers are threatened financially, HMO premiums drop, and business coalitions demand even lower premiums.

Managed care and capitation are changing irreversibly the way doctors practice. All regions of the country—urban, suburban, and rural—are affected by managed care, and as Medicaid and Medicare populations are converted to prepaid systems, the effect of managed care on each market will be compounded.

To compete effectively in this market, physicians need to be in groups. They also need capital, effective financial management, strong physician leaders, management infrastructure, and information systems. To meet the market's demands to reduce costs, physicians need to move quickly from disorganized fee-for-service to an organized group practice. One reason this change is imperative is that care is migrating quickly from high cost inpatient sites to low cost ambulatory sites. Most of this care can be rendered by organized group practices.

Why Groups Are Necessary

Purchasers recognize that as markets mature, care is shifting out of hospitals, and costs decline. The University HealthSystem Consortium, Oak Brook, Ill., an organization of university hospitals, estimates that market maturity can be defined as falling into one of four or five stages. (See "The Five Stages of Managed Care Development," PPO February.) HMO per patient per month (PMPM) premiums drop from $135 in Stage 1, to $128 in Stage 2, to $118 in Stage 3, to $103 in Stage 4. Premiums drop fastest in markets with large group practices. In California, where 50% of physicians are in groups of 100 or more, HMOs charge premiums of $80 PMPM.

Recognizing that physicians are at the center of the delivery system and responsible for 85% of health costs, purchasers want to work with physician groups to negotiate cost reductions. In California, physician groups have reduced hospital rates to 140 per 1,000 enrollees, well below the 225 per 1,000 rate HMOs have achieved.

One result of this trend is direct contracting between physician groups and large purchasers. Another result is contracting between HMOs and physician groups that have enough mass to assist HMOs in their marketing strategies. In general, if your group has a 20% share of any given market, one or more HMOs will likely seek to con-

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EDITORIAL

Why Managed Care Struggles in Rural America

Over the past few months, I've spoken frequently with physicians and hospital administrators in towns of 15,000 to 75,000. Most often these doctors and administrators are concerned about the future of managed care in their communities. Rural communities and the areas they draw from represent about 25% of the U.S. health care market.

As a result of research I've done for presentations in these towns and after speaking extensively with these hospital executives and physicians, I have found that rural health care differs in five fundamental ways from health care delivered in urban settings.

1. The population mix is more equally distributed among Medicare, Medicaid, and commercial patients. In rural America, Medicare patients represent 30% to 35% of cash flow, Medicaid about 27% to 33%, and commercial patients about 32% to 43%. Therefore, rural markets must pay more attention to Medicare and Medicaid politics and policies, and focus less on commercial markets. In cities, the commercial business dominates, taking some 60% of the market. After Medicare-risk contracts are approved and if the state government converts Medicaid recipients to managed care, a rural market can move from little managed care to 50% penetration virtually overnight.
2. Rural markets resist HMO penetration more than other markets for two reasons. First, rural areas have few large businesses and thus don't have the volume to cover HMO marketing and administrative costs. Second, rural populations can be expensive to cover because they may have pent-up health demands and high risks.
3. For-profit hospitals consider rural hospitals an attractive investment. If you doubt this, consider that Forstmann Little & Co., a New York investment firm, just spent $1.1 billion to acquire Community Health Systems Inc., in Nashville, a chain of 38 rural hospitals. And the 157-bed Cookeville General Hospital in Cookeville, Tenn., with revenue of $37 million, recently received 11 cash bids varying from $39 million to $100 million. The high bids came from large tertiary hospitals seeking patient referrals, and from for-profit chains looking to add to regional networks. These bidders believe the hospital has the potential to generate more revenue.
4. Rural areas often have acute shortages of primary care physicians and hospitals. Being few in number, rural hospitals and physicians have a relative monopoly. A study of 4,500 hospitals and 2,500 medical groups with five or more members showed that 70% of hospitals and 60% of group practices are recruiting. Done by Merritt, Hawkins & Associates, recruiters in Irving, Texas, the study showed that such recruitment is intense in these rural regions, including eastern Washington; Evansville, Ind.; Fargo, N.D.; the Mississippi Gulf Coast; North Central Florida and the Panhandle; Northwest Arkansas; the Quad Cities in Iowa; Springfield, Mo.; and West Texas. (For a free copy of the study, call Merritt, Hawkins & Associates at 800/876-0500).
5. Rural hospitals of 100 beds are often the economic lifeblood of a community, a recruiting magnet for physicians, and the only source of care for trauma, emergencies, oncology, and rehabilitation services for 200 miles or more. Managed care, slashed Medicare payments, and poaching by large urban systems threaten these hospitals and the communities.

If you have questions about addressing rural health care needs, we invite readers to ask us directly. Our mission at *Physician Practice Options* is to be a practical resource to help physicians to succeed in a rapidly changing health care environment. As such, we willingly make ourselves available to answer any and all questions from readers. We may not have all the answers, but we have tremendous resources at our disposal.

Richard L. Reece, MD
Editor-in-Chief
15 Banbury Crossing
Old Saybrook, CT 06475-2362

860/395-1501
Fax: 860/395-1512
E-mail: RReece1500@aol.Com

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Editor
Joseph Burns
508/495-0246
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Physicians in Staff-Model HMO Form New Group in Changing Connecticut Market

Connecticut is a managed care anomaly. It is the home of two managed care giants—Aetna-U.S. Healthcare and Cigna—and four of its HMOs—Physicians Health Services, Blue Cross Blue Shield, Connecticare, and M.D. Health Plan—have more than 150,000 members each. In 1987, the Connecticut State Medical Society organized a statewide HMO, M.D. Health Plan, that was sold last year for $100 million to Health Systems International, a for-profit HMO in Woodland Hills, Calif. Despite this level of managed care penetration, this New England state of 3.2 million residents has witnessed little independent consolidations among its 8,000 physicians or its 34 hospitals.

In general, physicians practice solo, in small groups, or clustered in IPAs around hospitals. Faculty practice plans exist at Yale University and the University of Connecticut Medical School. Kaiser has a moderate presence as a staff-model HMO.

Today, however, the remaining fee-for-service plans may be disappearing as physicians consolidate into management service organizations (MSOs) independent of hospitals. Three autonomous MSOs are being formed by physicians. One, Connecticut Primary Care MSO, in Bloomfield, has 175 primary care physicians and is being capitalized by a Boston venture capital firm. The second, Physicians Choice, in Ridgefield, has affiliations with 350 physicians and capital from PhyMatrix Corp., a physician practice management (PPM) company, in West Palm Beach, Fla. The third, Physicians Health Care Alliance (PHCA), in New Haven, has 44 physicians in seven locations and is seeking capital. Also developing MSOs are the state's major hospitals, Hartford Hospital, Yale-New Haven Hospital, St. Joseph and St. Vincent Hospital in Bridgeport, and St. Francis Hospital in Hartford.

Of these efforts, PHCA is interesting for four reasons:

1. Its roots are in a former staff-model HMO, Community Health Care Physicians (CHCP), of New Haven;
2. Its formerly salaried physicians have decided to form a private-practice corporation (CHCPhysicians) and develop an MSO to expand to other regions of the state;
3. Its physicians have the infrastucture, experience, and culture needed to succeed under capitation.
4. In their search for capital, the physicians want to retain physician governance and a majority stake.

Charles Hollander, MD
Medical Director
Physicians Health Care Alliance
New Haven, Conn.

In an interview, PHCA Medical Director Charles Hollander, MD, outlined why his group has decided to develop an MSO. "We saw two things happening in Connecticut," he says. "One was that there was a great need for primary care physicians, especially primary care physicians who had managed care experience. We also saw that in our part of the world, staff-model HMOs were not growing. We felt that with our experience as primary care physicians in managed care, we were in an excellent position to provide our services to other managed care companies.

"After all, we've been in existence for 21 years," Hollander continued. "We have a managed care management staff. We have NCQA accreditation, and we were able to produce a HEDIS report that was picked as a prototype for Blue Cross plans nationally." The National Committee for Quality Assurance (NCQA), is a health plan accrediting agency in Washington, D.C., that has developed the Health Plan and Employer Data and Information Set (HEDIS), a health plan quality-measurement tool. "We understood managed care and we had an experienced non-clinical management staff that could help us manage capitation and other fixed-budget kinds of payment," he says.

The only other organization prepared to accept capitation was Kaiser. Hamstrung by its structure, Kaiser is like other staff-model plans that have had slow growth and that are handicapped in a rapidly changing environment.

Recognizing the problems inherent with a staff-model structure, CHCP chose to convert to an independent professional corporation with an associated MSO. The recently concluded three-step process took 18 months. "We had to do three things at once," Hollander explains. "We had to dissolve the HMO. We had to organize the clinicians into a professional corporation, and we had to organize the non-clinical staff into a management service organization.

"Both the professional corporation and the MSO are for-profit corporations with a strategy of aligning with more physician groups to offer services over a broader market," he says. "Our object is to pursue alliances and to have contracts with other primary care groups. We have the management team, the information system, and the utilization protocols and guidelines to offer to other primary care groups."

The group's experience with capitation should be useful. "We can help other physicians manage on fixed budgets, to develop processes to improve quality, and to document the quality of their work," Hollander says.

In closing, Hollander offered this advice: "The ability to survive as a solo practitioner or in a very small group is very, very tenuous. I would urge physicians and other clinicians to look at options in which they can group themselves to have more clout in the market, and to organize themselves around an infrastructure to manage global budgets and to document their quality. Physician consolidation is inevitable, and it's the right thing to do." ■

Table 1: Estimated Market Maturity

An unstructured market is rated 1.0; a loose framework market is 2.0; a consolidating market is 3.0. A mature consolidated market (in which large health systems compete) is 4.0.

	1993	1994	1995
Nashville	1.5	1.6	2.1
Galveston, Texas	1.4	1.5	3.1
Oklahoma City, Okla.	1.5	1.7	2.6
Chicago	2.3	2.4	3.0
Madison, Wis.	2.3	2.6	3.1
Lexington, Ky.	1.2	1.7	2.2
Salt Lake City	2.3	2.6	3.1
Atlanta	1.8	2.1	2.7
New York	1.6	1.9	2.2

Source: University HealthSystem Consortium, Oak Brook, Ill., 1996.

(Continued from page 1)

tract with you.

The only practical way to achieve critical mass is through an integrated group practice in which doctors have an equity ownership, some financial incentive to cut costs, and the requisite infrastructure and information systems. In capitated markets, physicians in integrated groups with an equity stake and governance control have sufficient incentives to cut costs significantly.

Physicians should form a group of roughly 40% to 60% primary care physicians and the group should have at least a 10% to 20% share of a given market. As a business, the group should be separate from the hospital in order to give doctors an incentive to make their own economic and clinical decisions. Moreover, a hospital system and a physician outpatient practice are fundamentally different businesses.

The Struggle to Form Groups

Building a bigger and better group isn't easy, however, for four reasons. The chief reason is fragmentation. America's 684,000 physicians practice in about 400,000 locations, and 70% of physicians practice in groups of three or fewer. Even in local markets, physicians don't generally talk to each other about business problems or strategies. Simply getting busy physicians together is a demanding task because most have demanding practices. What's more, physicians don't like meetings and have little experience with organizational politics.

The hospital umbilical cord. A second reason physicians struggle to form groups is that many have trouble distancing themselves from the local hospital. Given their capital, executive skills, and community visibility, hospitals give up control to physician groups reluctantly. That's why hospitals are on a physician practice buying frenzy. Last year hospital-based systems reported a 60% increase in the number of physicians they owned or managed, rising to 11,233 in 1995 from 7,015 in 1994, according to *Modern Healthcare* magazine (June 3, 1996). Still, hospitals own only a small percentage of group practices. (See Table 2: Percentage of Groups by Ownership Interest and Group Size).

To date, most efforts to integrate hospitals and physicians under one roof have either lost money or haven't functioned well. Hospitals usually lose money running physician practices. Only 17% of hospitals that have bought practices have achieved a positive return. Overhead rises, salaried physicians' productivity drops, and hospital information, credentialing, billing, and management systems aren't designed for outpatient care. Hospital joint ventures with physicians, especially management service organizations in which physicians have a majority equity stake and majority governance, are being introduced, but have yet to be tried adequately.

Watch what happens over the next months and years as two capital-bearing entities—hospitals and outside investors—compete for physicians' loyalties. Physicians in groups should remember that when they sell to a hospital for what looks like easy money, they cancel the opportunity to sell out to another entity or to go public later.

Physician time, money, energy, and experience. The third reason physicians have had trouble forming groups is that doing so requires a considerable investment of time, money, energy, and experience. At least one year may be needed, tens of thousands of dollars, and countless man-hours to compile data, plan, and execute a strategy. You may save time but pay more by hiring a consultant. Forming a group is especially difficult in communities that do not already have groups. In these towns, it may be difficult to persuade physicians to explore the unknown.

Market demands. A fourth reason is that physicians are wavering, trying to understand market demands. In the next five years, the market will demand reductions in Medicaid, Medicare, and commercial premiums of 25% to 30%. It also will demand that groups operate within a budget by making the transition from fee-for-service to prepaid care. Already, purchasers demand that physicians cut costs by 30% and provide care that is more convenient and accessible while maintaining or increasing rates of satisfaction and quality.

Assessing the Market

To form the proper group for a given market, one needs to assess the market accurately. Among the characteristics to review are the size of the market, its capacity for growth, and its place on the road to managed care. In general, you have to understand the local business and political culture, the degree of experience with managed care, the strength of the existing health care organizations, and the magnitude of the excess capacity of hospitals, physicians, and premiums. The Center for Studying Health System Change, in Washington, D.C., has more information on determining the level of managed care in different communities. The center is focusing on changes in the health system in 60 sites representative of the nation.

Physicians are just becoming aware of the process they need to follow to form a cohe-

Table 2: Percentage of Groups by Ownership Interest and Group Size

Ownership	Group size by number of doctors					
	3 to 15	16 to 25	26 to 49	50 to 75	76 to 99	>100
Physicians	94.5%	83.0%	82.7%	79.2%	91.6%	64.1%
Hospitals	2.1%	6.3%	4.2%	11.5%	9.8%	9.4%
MSOs	0.8%	1.5%	2.9%	4.8%	4.9%	1.6%
Universities	0.7%	8.2%	9.6%	6.4%	2.7%	17.1%
Insurers	0.1%	0.0%	0.5%	1.4%	2.7%	0.0%
HMOs	0.2%	0.2%	1.9%	1.4%	2.7%	3.1%
Other	1.5%	4.7%	6.7%	7.5%	6.4%	12.4%
Total groups	15,023	760	420	115	81	125

Source: Medical Groups in the United States, American Medical Association, Chicago, 1996.
Note: Percentages total more than 100 because groups could check more than one response.

sive group capable of attracting capital. Those who want to invest in physician groups are looking for credible physician leaders respected for their clinical and business skills. Also, they want groups that have strong governance, a solid business plan, a management team, a track record of accomplishment, and the systems to compete for managed care contracts.

Once your group understands the process, you will likely want to know the best time to proceed. Generally, one should move to form a larger organization before 15% of the population is enrolled in managed care, and the average HMO market penetration in the United Stated already is at 20%.

A number of sources are available to help you gauge the level of managed care penetration in your market. One such method has been developed by the University HealthSystem Consortium based on multiple market variables. (See Table 3: Ten Variables in Three Markets.)

Finally, the process of forming a group requires due diligence, an assessment of the market, a profit-and-loss analysis, an examination of strategic options, and implementation of business plans. The processes generally require an outside consultant, cost more than $25,000 depending on the size of the group, and can take 36 weeks to complete. The rapid maturation of managed care in markets nationwide, the chaotic transition from fee-for-service to capitation, and the sweeping cost reductions requiring moving care outside of hospitals make group formation imperative for physicians seeking to continue to practice with clinical independence. ■

For more information

The Center for Studying Health System Change
600 Maryland Ave., SW, Suite 550
Washington, D.C., 20024-2512
202/484-5261
Fax: 202/484-9258

University HealthSystem Consortium
2001 Spring Road, Suite 700
Oak Brook, Ill., 60521
708/954-1700
Fax: 708/954-4730

Table 3: Ten Variables in Three Markets
(Market stage)

Market Variables	Minneapolis	New York	Pittsburgh
Percentage of population enrolled in HMOs	39% (3)	13% (2)	17% (2)
HMOs >100,000	3 (3.5)	2 (3.5)	1 (2)
Percentage of HMO members in top-three HMOs	93% (4)	78% (4)	87% (4)
PPOs >100,000	4 (3.5)	2 (2)	1 (2)
Percentage of state employees in HMOs	58% (2)	20% (1)	15% (1)
Hospital occupancy	67% (3)	90% (1)	74% (2)
Inpatient days/1,000	695 (4)	1,205 (1)	1,361 (1)
Percentage of beds in health systems	60% (3)	37% (2)	33% (2)
Percentage of capitated MDs	56% (3)	60% (3)	11% (3)
Business coalition impact	4	3	1
Maturation index	3.5	2.2	1.8

Source: University HealthSystem Consortium, Oak Brook, Ill., 1996.

How a Rural Physicians' Group Prepares for Managed Care

James G. Nuckolls, MD
CEO, Blue Ridge Health Associates
Galax, Va.

James G. Nuckolls, MD, *is a specialist in internal medicine and the CEO of Blue Ridge Primary Care, Galax, Va., a family practice, internal medicine, and OB/GYN group practice with 120 doctors in rural Western Virginia. He also serves as an associate professor of clinical medicine at Duke University. A member of the editorial board of* Physician Practice Options*, Nuckolls has authored numerous articles for magazines and other publications, including* JAMA*,* Hospital Practice*, and the* Annals of Internal Medicine.

Q: *Dr. Nuckolls, what's the nature of your practice and where is Galax, Va.?*

A: Galax, Va., is in the western part of Virginia. People from Washington call me frequently and want to come out and see our practice. I tell them, "That's great. I'd love for you to come out, but it's the same distance from Washington, D.C., to Galax as it is from Boston to Washington. People don't know how long Virginia is. We are out here in the Blue Ridge Mountains, called the Appalachian area, and this is actually my home. I've been in practice here for 23 years.

Q: *Do you practice in a group?*

A: Yes. We have an internal medicine group. I'm an internist who started solo and added on internists. We currently have five internal medicine doctors in our group, and last year we merged with a family practice group of three family practitioners, and one nurse practitioner was in that group, so now we have a group of nine physicians and one nurse practitioner.

Q: *How big is the area around there? Could you describe the market?*

A: Our drawing area in my particular community here is 60,000 people. We have a 150-bed hospital, and we have approximately 55 physicians on the medical staff in our hospital, and we serve two counties in the western part of Virginia. We're about 60 miles from the nearest tertiary center, which is Bowman Gray Medical School in Winston-Salem, N.C. That's our nearest hospital. We're right on the North Carolina-Virginia line, but also not too far from Tennessee and only about 50 miles from West Virginia.

But we're a part of a larger organization now known as Blue Ridge Primary Care, which is a group of 120 primary care doctors that extends 300 miles down the Interstate 81 corridor in Western Virginia, actually starting near Winchester, Va., and going all the way to the end of the state on the road to Abingdon, Va., which is almost in Tennessee, and that's the span of our primary care practice group.

Q: *Are you positioning yourself for a managed care future?*

A: Our vision has been that managed care is coming, and we're trying to prepare for that. Right now there's very little. We have no capitation in our area of Galax. There is a Blue Cross-Blue Shield plan in Blacksburg, Va., which is the home of state's largest university, VPI, Virginia Polytechnic Institute. Blue Cross has offered a capitated option on its health insurance plans, and some people in that area have selected that plan, but that's the only capitated contract that's anywhere near here.

Other than that, what we see happening is industries looking at how their health care services are being delivered and starting to add some preferred provider lists. They're starting to have the gate-keeper type of approach. In other words, they want someone to see the patient before they go directly to a specialist. If one of the employees goes directly to a specialist, the employee must pay more out-of-pocket. We're starting to see that type of managed care. We haven't had people coming in and asking for large discounts yet, simply because we're still in a health-workforce deficient area, so to speak. There haven't been enough primary care physicians in our area through the years. It seems that we have more specialists but very few broad-based physicians.

Q: *How are you positioning yourself? What organizational format are you adopting?*

A: We feel that the strongest player in our market is the hospital system. We have competing hospital systems: The not-for-profit hospitals are in our area, but also there is a for-profit hospital that is strong in our area, Columbia/HCA. The strongest system in our area is a hospital system known as Carilion, which either manages or owns 17 hospitals in this area. They are the big bear in our market. They have Carilion Health Plans which already has some insured lives. For the most part, they do wholesale insurance and provide the network for Blue Cross-Blue Shield, and also for some of the HMO products in the area.

Since Carilion has 80% of the hospital beds in our area, we feel we needed to partner with the power. They're going to be here long-term. They have shown us that they have a good vision for the future, and they realize that the future of health care delivery and success of hospitals isn't in doing services and procedures. They realize that the future is in helping physicians manage care. They also realize that they need to manage data and information in order to help physicians manage care more effectively.

They also understand that they have to move from more administrative management to more physician management in order to accomplish this goal if their income in the future is going to come from managing health care dollars and not in doing more services and procedures. They view the future as if they will be cost centers rather than revenue generators. With that kind of foresight, their vision of the future is very similar to our physician group's vision.

We believe that doctors are not going to get higher salaries. Physicians are not going to make more money by raising physician fees. If they are going to maintain their status quo with their income stream, they're going

to have to reduce overhead. There's great advantages in overhead reduction by joining together in larger groups. Everybody doesn't have to have a practice manager. Everybody doesn't have to have a lawyer to review each contract. In our internal medicine group, we deal with 453 different payer systems, so we can get tremendous economies of scale, especially in information systems as they become more available.

Q: *What organizational form is this taking? A PHO or an MSO?*

A: We started out to form a single group practice, and we were going to do that by the first of this year. But because it seemed like our negotiations were going too well with developing a capital partner and setting up a new company, which will be a managed care organization with the hospital system, we thought that our energies needed to be applied to trying to do that deal rather than completely merging our practices. Right now we have 40 of our 120 physicians in a single group practice, and the other 80 physicians are stockholders in Blue Ridge Primary Care. We haven't merged our pension profit-sharing plans yet, but we've had all the plans reviewed and we're ready to do that. If this deal falls through with the hospital system, we plan to be a single group practice with one billing number, merged assets, and we'll have our own management system.

Q: *And you'll be glued together by a common information system?*

A: Yes, by a common information system. By law, of course, we have to have common benefit programs and common profit-sharing plans. All that structure has to be in place to be a single group practice, to be able to negotiate as a single practice, to be able to bill as a single practice. And, then, we will put together the information system. As we put together our information system, I hope that we can start with the information systems that we have and go to those companies that can link us together as we are, using what computers we have and what software programs we have. I would like to meld those systems together to start. Then as we get capitated contracts and need much more information on what each doctor does each day, then we can gradually work in more sophisticated management types of software.

Q: *Do you look to a future of managing the clinical side of the business to function efficiently in a capitated environment?*

A: I think that that's the only way that we can take on risk. If we want to take a capitated contract and be at risk for it, we have to be able to manage clinical care or we have to know what our doctors do each day.

"Specialty care physicians want to maintain fee-for-service models as long as they can, but, primary care physicians are ready to move to more managed care environments where they can do somewhat better in those types of environments."

Q: *You seem to have been undergoing a crash course in educating yourself under the business side of medicine here.*

A: It's amazing. When your practice is involved and the practices of your partners are involved and you see your community changing that's a real stimulus to get an education about this.

Q: *Realistically, what do you see as doctors' options in this rapidly changing environment?*

A: Well, I think that many doctors don't realize they have many options, and it's interesting that I'm going to be on a panel this Sunday discussing managed care, and the leader of that panel discussion sent me a series of questions that were going to be asked of the panel members. And as I looked at the questions, they were questions that had to do with managed care contracts: What should we take as a capitation rate? What would be a fair payment for this, or a fair payment for that? It really made me nervous when I started looking at that, because I'm afraid that's how so many doctors are looking at managed care. They're looking at managed care contracts. What I'm interested in, and where I think practice management needs to focus, is way upstream from the managed care contract. I think those involved with practice management need to control the entire process. Physicians need to gain control of the insurance premium, and then the doctors won't have to worry about the insurers putting the screws to them, so to speak. The doctors will be determining what physicians are paid. These decisions need to be made by physicians.

Q: *How do they control the insurance premiums?*

A: Well in order to do that, they have to have a large enough presence in their market. So each doctor has to merge, amalgamate, learn how to work with his or her colleagues, and understand how to become a team player. In addition, you have to have the right incentives in place with each other in order to get that done. It's very hard initially when managed care comes into a market for all the physicians to have their incentives aligned appropriately. Specialty care physicians want to maintain fee-for-service models as long as they can, and I can certainly understand that. But, primary care physicians are ready to move to more managed care environments where they can do somewhat better in those types of environments. I think the incentives in our market are misaligned. But there is a point in time as managed care becomes more prevalent in a marketplace where specialist and primary care incentives become more aligned in appropriate clinical care management. Each marketplace varies as to how the initial collection of doctors needs to come together.

Q: *It is said that once managed care in the form of capitation exceeds 30% collectively, the doctors suddenly realize that the game is controlling costs, not generating revenues.*

A: Exactly. I've heard that, I've heard 30% to 40%. All the specialists pay attention to that. In the Richmond, Va., market, the Blue Cross-Blue Shield company for Virginia has entered into a contract with two orthopedic surgeons to do all of their knees, hips, and shoulders for a fixed price. That's what's happening. And doctors have to be ready when it comes to their market. ■

Tracking Physician Practice Transactions

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

The pace at which physician practices are being acquired has never been faster, increasing from 24 in 1993 to 121 in 1995. A factor contributing to this trend is the growing number of publicly traded physician practice management companies (PPMs). Three years ago, seven PPMs were publicly traded. Today there are 31. Despite this increase, only about 5% of U.S. physicians are currently affiliated with publicly traded PPMs. (See tables 1 and 2.)

Reacting to the consolidation taking place in health care, physicians are forming larger groups. The total number of groups in the United States with more than 25 physicians increased over 11% between 1993 and 1994. We estimate that by 2000, almost 40% of all groups will have more than 25 physicians. (See tables 3 and 4.)

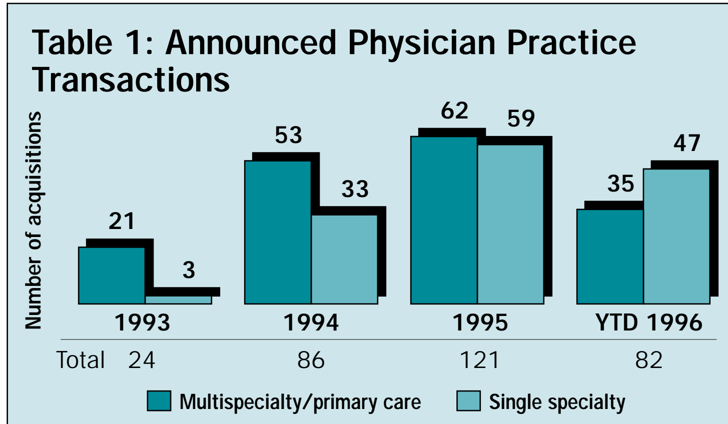
By studying the publicly announced transactions, trends can be seen. First, purchase prices paid for physician practices have risen over time, reflecting the increased demand and competition for all types of practices. The average per physician purchase price has nearly tripled since 1993 to approximately $935,000 per physician. The average revenue multiple has grown over 50% since 1993. In part, this increase can be attributed to an increase in the number of acquisitions of single specialty groups, which generally sell for higher multiples. (See tables 5 and 6.)

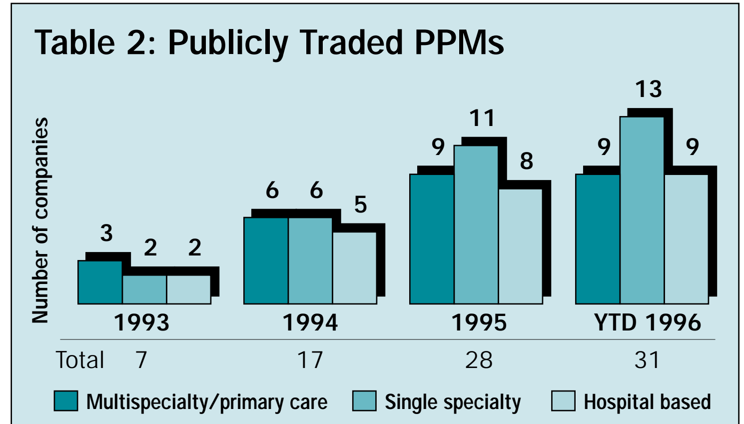
Single specialty groups have historically realized higher valuation multiples than the primary care or multispecialty groups. This fact can be attributed largely to the relatively higher per physician revenue and earnings potential of single specialty physician groups. (See tables 7 and 8.)

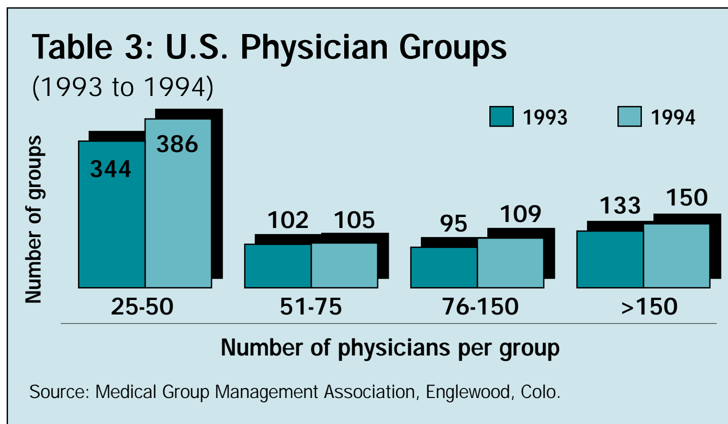
Since publicly traded PPMs have ample cash reserves from recent public offerings and because price-to-earnings multiples exceed current acquisition multiples, PPMs are positioned to pursue aggressive consolidation strategies. During the first six months of 1996, PPMs have raised approximately $1 billion in capital. Additionally, the high earnings growth rates have enabled most PPMs to outperform the market. However, recent price declines have brought these valuations in line with the overall market. (See tables 9 and 10.)

(Notes to tables: All 1996 data are as of June 30, except as noted. All tables are based on data available publicly. Source for all charts: Townsend Frew & Co., Durham, N.C., except as noted.)

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







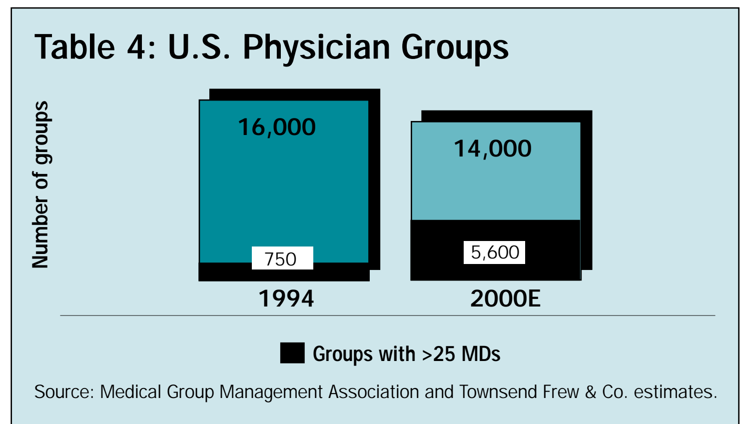


Table 5: Average Purchase Price Per Physician

(Multispecialty and single specialty combined)

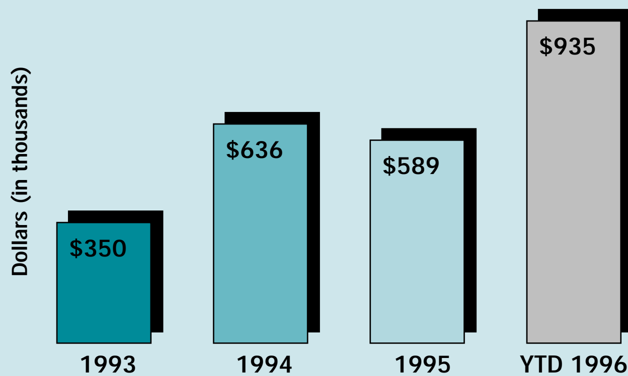


Table 6: Average Purchase Price to Revenue Multiple

(Multispecialty and single specialty combined)

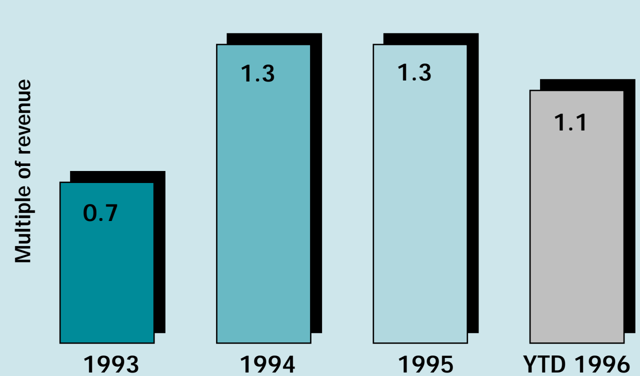


Table 7: Average Purchase Price Per Physician

(Based on transactions since January 1995)

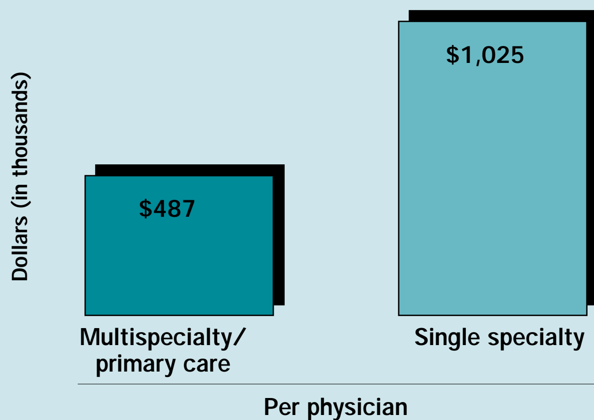


Table 8: Average Purchase Price-to-Revenue Multiples and Enterprise Value-to-Revenue Multiples

(Based on transactions since January 1995. Enterprise value is equal to share price times outstanding shares plus net debt.)

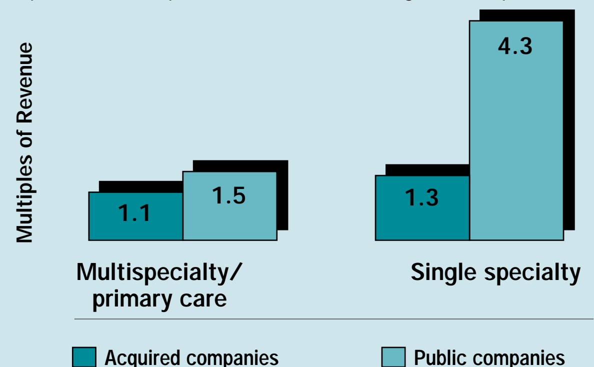
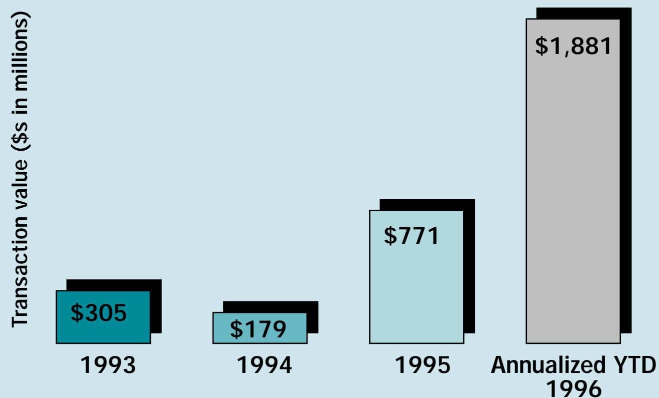


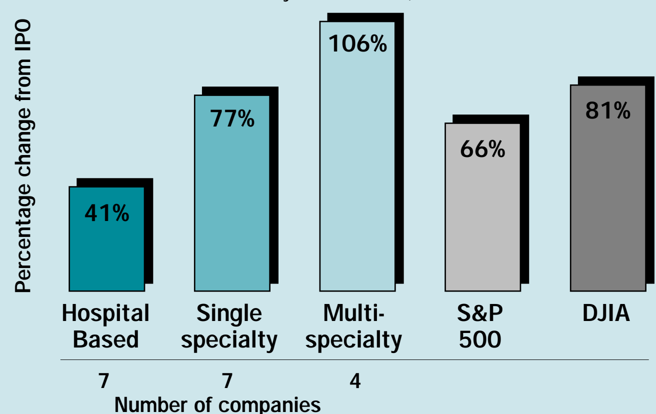
Table 9: Total Capital Raised by Public PPMs



Source: Securities Data Co., Newark, N.J., and Townsend Frew & Co.

Table 10: IPO Aftermarket Performance of PPMs

(Data as of July 16, 1996. Dow Jones and S&P 500 returns from June 21, 1991, to July 16, 1996.)



Preparing for Investment Part Two, Building Value

By Marc S. Margulis

Determining the value of a physician organization is not unlike appraising diamonds. A two-carat diamond is worth more than twice as much as a one-carat diamond. Also, size is not the only determining factor. When valuing a diamond, one also considers color, cut, and clarity. Like diamonds, all provider organizations have value. And, like diamonds, not all provider organizations are valued equally in terms of a price per physician, a price per life, a percentage of annual revenue, or a multiple of earnings or cash flow.

When investors evaluate the worth of a physician practice, they generally will prepare projections of revenue and expenses, including physician compensation and benefits. They may consider the economic effect of converting fee-for-service lives into prepaid lives and the effect of assuming additional risk through full-risk capitation. In some cases, it may be appropriate to consider the effect of assuming global capitation.

In general, however, the bigger the group practice, the more value it has per physician. The more capitated lives under contract, the more value it has. The more sophisticated the information system and the more business acumen its management team possesses, the more value it has. The greater the required compensation to physicians or other providers of care, the less value it has. The key to increasing value is to manage care effectively under capitated contracts.

Capitation is not one of the four horsemen of the apocalypse. Full risk and global capitation contracts can be extremely lucrative when well-managed. Managing care well, however, requires substantial capital and management commitments. The capital requirements are, in fact, so substantial, in addition to the executive leadership and vision required, that few provider organizations can or should remain independent of a financial and management partner indefinitely. Given that fact, we advise all physicians to move along the value continuum as far as possible before selling or partnering.

Building Value

To build value in a physician organization, we recommend a 10-step approach, as follows.

Step 1: Consolidate. Fundamentally and generically, an IPA is worth more than a solo practice; a clinic without walls is worth more than an IPA; and a group practice is worth more per any unit of measure than all of the above. Take, for example, 40-plus solo practitioners in Northern California who formed a clinic without walls (in this case, a group practice in legal documents only) to negotiate an acquisition by Sutter Health. As a result, the physicians could execute a deal upon substantially better financial terms than they would have been able to negotiate individually. A better strategy would be to go beyond the legal formation of the group practice and physically consolidate practice sites, centralize administration, and obtain managed care contracts.

Step 2: Acquire managed care contracts. Start with PPO contracts and move into pre-paid contracts. The group should seek contracts with multiple health plans for obvious reasons.

Step 3: Increase productivity. A primary care physician should see between 28 and 32 patients per day during a 4.5-day week, 46 to 48 weeks per year. In a multi-specialty group practice, the physicians should see, on average, somewhere between 18 and 22 patients per day. As a rule of thumb, each PCP should manage the health of at least 2,000 commercial patients; a new physician should be added only for each additional 1,200 to 1,500 lives.

Step 4: Manage utilization. In other words, take risk and invest in the infrastructure necessary to manage care and make money from it. Doing so requires that you build effective lay administration and medical management, including utilization review, case management, and a strong medical director who has the respect of the doctors in the community.

Step 5: Invest in management information systems (MIS). Managing care profitably requires information, lots of information, and much of it in real time.

Step 6: Minimize fixed costs. Physicians' compensation is frequently the largest fixed cost component of physician organizations. Preferably, physician compensation should be subrogated to the costs of operating the MSO functions of the organization and should be comprised of modest base salaries plus a significant incentive component, the subject of the next step.

Step 7: Implement meaningful incentive compensation programs. There are a number of successful incentive compensation formats. The most successful start simply by choosing a single behavior to change or promote and designing an incentive plan to affect that one behavior. When that behavior becomes instilled in your providers, then decide on the next behavior to modify and change the incentive compensation system to achieve that second objective. If you try to do too much too soon in a single incen-

__Marc S. Margulis, CFA, ASA, MBA,__ is a managing director and co-director of the health care practice at Houlihan Lokey Howard & Zukin, a financial services and specialty investment banking firm, in Los Angeles. An Accredited Senior Appraiser and a Chartered Financial Analyst, Margulis has more than 10 years of experience as a financial adviser to physician practices, HMOs, hospitals, and other health care providers. This article was adapted from a presentation Margulis made at the Physicians' Capitalization conference in Boston. It is the second of two parts. Part one, "Creating Leverage," was published in June-July.

tive compensation plan, it will be ineffective. Also, unless a substantial percentage of total compensation is addressed by the incentive plan, at least 30% of total compensation, it will be ineffective at altering practice behaviors.

Step 8: Don't buy what you can rent for less. In other words, why bring on an oncologist or a thoracic surgeon at a high fixed cost when you can contract or sub-capitate? Why buy a building when you can lease it? Your maxim should be: rent, don't buy; contract, don't own.

Step 9: Spin off the management services organization (MSO). Separate your organization into two entities, a PO (provider organization) and an MSO. This corporate structure facilitates later recapitalizations or transactions, particularly in those states that prohibit non-physician ownership of medical assets.

Step 10: Market the MSO or ASO (administrative services organization) to other providers. Form a wrap-around IPA or contract to provide administrative services to an existing IPA. Or offer practice management services to independent physicians. Since these strategies are what physician practice management (PPMs) companies employ after they buy your practice, why not do it ahead of time and capture the value of these strategies for yourselves?

> **"Does the acquirer have an investor-driven culture or a physician-driven culture? The majority of the capital in health care is tied up in so called not-for-profit systems, which does not necessarily mean nonprofit. Some are very profitable. They're just not investor-driven."**

A Baker's Dozen of Health Care M&A

When you are ready to negotiate with a prospective partner or acquirer, be prepared to negotiate more than just price. In fact, after having been involved in or having initiated scores of transactions, we have encountered 13 categories of issues that should be addressed during negotiations leading to a definitive agreement. We call these the "baker's dozen of health care mergers and acquisitions."

These thirteen deal points are as follows:

1. Acquisition model. Stock purchase or asset purchase? Nonprofit or for-profit? Newly created subsidiary or absorption into an existing business unit? Purchase of the whole or partial purchase?
2. Price. Cash, stock, or trade? Price, however, cannot be discussed without reference to the third and next deal point.
3. Terms. You've heard the expression, "I'll pay you any price you want as long as you give me any terms I want." Full payment up front or cash plus a payout? What is the pay out term? Will interest accrue?
4. Post-transaction compensation structure. Fixed salaries or a percentage of fee collected? If variable, what percentage? If variable, is the amount paid to the group to distribute as it sees fit or to individual doctors directly? See, also, performance incentives.
5. Compensation guarantees. After the transaction, will the buyer guarantee a minimum compensation level for some minimum period?
6. Performance incentives. Is there an incentive component of compensation in addition to the previously defined compensation structure? If the group does better than projected, will the physicians share in such unanticipated profits? Can the physicians share in increased value of the organization?

> **"To make an incentive compensation plan work, address just one behavior that you want to change. Design your incentive plan for that behavior, and when it becomes instilled in your population, decide on the next behavior to modify. If you try to change too many behaviors in a single incentive compensation plan, it will fail."**

7. Unwinding procedures. If it's a bad marriage, how do we get out of it and how do we get our assets back intact? And for what price?
8. Access to capital. How much capital will be available to us, for what applications, and at what cost? What will the parent charge the subsidiary to borrow money? Do these charges fall above or below physician compensation?
9. Territorial exclusivity. If the intent is for the physicians to grow in their market, will the physicians have that market exclusively, or will the parent add other operations in the same service area that will compete against the first group?
10. Governance and accountability. Do the physicians have representation on any committees or boards? To whom are the physicians accountable?
11. Economies of scale and other synergistic benefits. Will the parent pass any economies of scale along to the physicians in the form of reduced costs for services provided?
12. Culture. Is it an investor-driven culture, a physician-driven culture, or a society-driven culture? The majority of the capital in health care is tied up in so called not-for-profit systems, which does not necessarily mean nonprofit. Some are very profitable. They're just not investor-driven. Instead, they are society-driven.
13. Ancillaries. Other deal points include non-compete covenants, exclusive provider and service agreements, standards for professional conduct and accessibility. ■

STRATEGIES

What You'll Need for Capitation

By Kathy Zaharias, R.N., M.B.A.

Kathy Zaharias, RN, M.B.A., *is a health care management consultant with Milliman & Robertson, actuaries and consultants, in Irvine, Calif. A registered nurse since 1973, Zaharias has worked with a wide variety of managed care delivery systems and health care providers, including physician groups and staff-model HMOs. A specialist in assessing, developing, implementing, and managing operational systems in medical groups and clinics, Zaharias has developed, evaluated, and negotiated capitation contracts, including those that contain quality and service-performance criteria. She has a bachelor of science degree in nursing from the California State University of Long Beach and a master of science degree in Business Administration from the University of Phoenix. This article is part one of a two-part series. Next month, Zaharias will detail a case study about a health plan that opened a new center to serve a senior population.*

As managed care becomes the predominant mode of reimbursement, cost pressures require medical groups to review their practice style, particularly, the ambulatory component. The typical medical group's infrastructure and operational systems do not adequately support managed care or capitation. The financial implications of managed care and the diverse requirements of multiple contracted partners exacerbate the problem. To succeed, each medical group must function efficiently and cost effectively, while ensuring that quality care is delivered.

Financial Management

When a medical group assumes financial risk under capitation and accepts a fixed payment, it hopes that the resources needed to deliver appropriate medical care will cost less than the capitation payment it receives. The financial incentives of traditional fee-for-service reimbursement are in conflict with capitation payment. Under the fee-for-service model, the physician received payment after every patient encounter in the clinic and hospital. As encounters increased, revenue increased. The opposite occurs under capitation. When the reimbursement for medical services is pre-paid, the revenue per service decreases as patient encounters increase. (See Table 1: Comparing Fee for Service with Capitation.)

As a result of these changes, there is a drastic shift in how revenue will be spent. Under fee-for-service, it is unnecessary to develop strategies about where and when each patient would receive medical services because every patient encounter typically generates revenue. Once capitated, the challenge becomes to provide the right care at the right time and in the right place. The care should be provided by the provider with the appropriate skill level and in the appropriate setting. Ideally, the cost should reflect the two.

Additionally, moving from fee-for-service to pre-payment causes a dramatic change in financial reporting. Fee-for-service reimbursement requires that patient encounters be documented, tracked, and that a bill is produced. Pre-payment under capitation requires monthly tallies of enrollment and revenue, followed by accurate tracking of services rendered throughout the month. The end-of-the-month reconciliation compares revenue from pre-payment with the services rendered and should reflect financial performance accurately. The objectives of this process are to evaluate continually the appropriateness of resources expended to achieve an outcome and to assure the adequacy of the capitation being paid by the HMO or insurer. (See Table 2: Changes in Financial Reporting.)

Financial accrual and reporting systems require that utilization data be captured accurately and that costs, using that data, are calculated accurately. Such systems also allow reviewing and reporting the data. The scope of the tracking and financial accruals will depend on many factors, including the number and characteristics of the enrolled population and the services for which the medical group can accept risk, including any or all of the following:

1. Inpatient care (including acute care, skilled nursing care, and out-of-area care);
2. Emergency care;
3. Professional;
4. Pharmacy;
5. Outpatient imaging, laboratory, and surgery;
6. Rehabilitation;
7. Mental health;
8. Home health and home infusion; and
9. Health education.

The tracking and documentation mechanism needs to reflect the group's financial performance accurately. To ensure that the contract works for both parties, the tracking and monitoring of utilization under capitation is as important, if not more important, than it is under fee-for-service. Additionally, utilization data are required by HEDIS for future comparative measurements and employer groups making purchasing decisions. The Health Plan and Employer Data and Information Set (HEDIS) has been developed by employers, HMOs, and the National Committee for Quality Assurance (NCQA), a health plan accrediting agency in Washington, D.C.

Due to the financial implications of capitation, decisions regarding utilization and cost should be made only after considering the clinical and business components equally. To accomplish this goal, a group would need a physician and administrator team. If a patient requires an elective orthopedic procedure, the physician may provide an opinion regarding the clinical appropriateness of the procedure, the appropriateness of an outpatient versus inpatient setting, and the preferred clinician. The administrator or manager would provide information on the implications regarding facility, contract, and cost. Together, this management team would integrate the clinical and the business expertise in the decision-making process to manage utilization effectively.

Infrastructure

Health plan members need to be managed effectively in the ambulatory care setting, and management must ensure that members have access to the primary care team. The challenge for any physician group comes when developing quality measurement systems while also developing operational systems that enhance effectiveness, minimize potential burdensome requirements, and support the primary care physician's expanded role. The group can meet this challenge effectively by developing the following systems:

1. Utilization/quality/case management systems, which preserve resource consumption and allocation.
2. A specialty referral and prior authorization system, which ensures efficient coordination between specialty and primary care.
3. A patient access system, which ensures members have access to needed services.
4. A management information system, which ensures timely and accurate data to the physician and management team for sound decision-making.
5. Member service, which identifies and resolves members' complaints, and coordinates communication and follow-up.
6. Paneling process, which supports the creation of a relationship between a physician and patient while providing continuity of care.
7. Personnel mix and staff development strategies, which ensures that members have access to the provider with the appropriate skills.

Utilization Management

An efficient utilization/quality/case management plan is one that provides cost effective medical services and ensures appropriate levels of quality care throughout the patient's entire treatment. The physicians need to be responsible and accountable for utilization when accepting financial risk and appropriately utilize the available health care resources. Clinical practice guidelines have become a critical component of this process and require that physicians participate in their development and usage. Once the primary care physician's scope of practice has been determined and their skills defined, appropriate training should be provided for any deficiencies.

A team conference is an effective forum to discuss the appropriate management of patients. Typically, an experienced team will hold such conferences weekly. A less experienced team will meet more frequently.

The utilization team should have seven to eight members, including three to four physicians (some of whom are experienced and some of whom are newly trained), a utilization management nurse with knowledge of inpatient and community resources, a clinic nurse supervisor or team leader with knowledge of personnel and patient information, and a clinic administrator or manager with knowledge of cost and contractual issues. Also the team would include contracted specialists and a clinical pharmacist, when necessary.

Ideally, the team would meet once each week for one to two hours to develop criteria for case evaluation, which might include patient management problems, high dollar cases, targeted specialties, and all cases of new physicians. Included on the agenda should be quality indicators, member service issues and trends, member access, and readmission review. It is best to make decisions by consensus; however ultimate authority would rest with the primary care physician. The team should develop a work sheet with an action plan, and a responsible party should be designated for follow-up.

Using such a system, the group will find that specialty referrals will decrease and medical care will be provided by the provider with the necessary expertise. Moreover, medical care will be provided in the appropriate setting, and only those services that are medically necessary will be delivered.

Specialty Referral

When the treatment of a patient's medical condition is beyond the primary care physician's scope of practice, as outlined in the clinical practice guidelines, the patient should have timely access to a specialist. The contracted specialty network should include physicians who are managed-care friendly and willing to participate in the utilization and quality management team meetings. The specialists should perform only procedures that have been authorized and should communicate their written findings and recommendations in a timely manner to the primary care physician. In addition, the specialist should support the relationship between the primary care physician and the patient by referring all subsequent care issues back to primary care. It is important for the medical group to develop an efficient system that not only tracks the patients that have been authorized to see specialists, but encourages patients to keep their appointments, and ensures that they receive the appropriate follow-up care.

Table 1: Comparing Fee for Service with Capitation

	Fee for Service	Capitation
Increased inpatient occupancy	Increased revenue	Decreased revenue
Increased patient visits	Increased revenue	Decreased revenue
Decreased patient visits	Decreased revenue	Increased revenue

Patient Access

Patients need access to necessary services within the medical care system, particularly to a member of their primary care team. The group can ensure appropriate access by developing scheduling and staffing mix strategies that incorporate physician extenders and nursing telephone consultation. Also, the group can use paneling systems that assist members in selecting the appropriate primary care physician, and that support that relationship.

Although the availability of appointments is a critical component of access, it is also important that the medical center be conveniently located and open during favorable hours and days, that medical care is available when the medical center is closed, and that each member can reach the physician or a team member by telephone if necessary. To ensure that these systems work as planned, each one should be monitored closely.

Information Systems

To function effectively under capitation, the medical group needs accurate information on the at-risk population. The ideal information system would provide readily available and accurate reports tailored to meet the medical center and primary care provider's needs. Capitated members need to be identified along with the associated revenue and costs, and summarized by primary care physician for accurate profiling. Specialty encounters should be captured as well so the group can profile the network specialists.

The system should be electronic and it should capture the clinical data and associated costs. This information needs to be accurate and provided to the physician and management team for review periodically. The information should reflect

- Enrollment activity,
- Paneling activity,
- Member complaints and grievances,
- Member disenrollments,
- Inpatient and outpatient utilization,
- Outside specialty cost occurrences,
- Operating expenses, and
- Profitability.

Member Services

Mechanisms should be developed to elicit patient and member feedback to identify member requirements, to raise management's awareness of the member's perspective, and to identify opportunities for improvement.

NCQA requires that each HMO has a coordinated system in place to resolve and monitor member complaints and grievances. This standard applies for physicians or medical groups that are contracted with NCQA-accredited HMOs. Assuring the sustained satisfaction of members requires an integrated and coordinated system that identifies, resolves, communicates, and follows-up on any issues expressed by a member. Member complaints should be tracked and grouped to determine if the issue is an isolated incident or a recurring problem. If a problem is identified, this system will reflect progress toward resolution.

Table 2: Changes in Financial Reporting

Fee for Service	Capitation
Tracking and documenting patient encounters	Tracking and documenting enrollment, revenue and patient encounters
Billing for services rendered	Reconciling pre-payment of revenue to services rendered
Reconciling payment to services rendered	Financial accruals

Patient Paneling Process. The expanded role of the primary care physician would be supported by the paneling process. The process starts when a member selects a primary care physician at enrollment. Systems or processes need to be in place to support the creation and ongoing relationship between the patient and the physician or a physician team member. The optimal system assists the member in selecting a primary care physician during enrollment. An effective paneling system is electronic and should coordinate communication processes which inform and educate members regarding their options about selecting, meeting, and changing physicians. The system also would provide the primary care team with timely and accurate information to manage panels effectively. Additionally, the system would provide the primary care physician with the appropriate remuneration when reimbursement is based on panel activity. Finally, it would track patients who have not yet designated a primary care physician.

Personnel Mix and Development. The financial effect of managed care makes nursing and mid-level physician extenders a cost-efficient option that can support physicians by enhancing their productivity. They can afford physicians the opportunity to care for more severely ill patients and complicated cases. The physicians supervise the team instead of actually performing the tasks.

Mid-level physician extenders may be used effectively to perform such tasks as health screens, urgent visits, routine pre- and post-surgical follow-up visits, minor surgeries, and routine deliveries. Once physicians familiarize themselves with the mid-level practitioner's scope of practice, the doctor may find himself or herself in the role of a coach or supervisor. Since it has been estimated that approximately 85% of all outpatient visits can be performed by primary care physicians, the mid-level practitioner or physician extender may be highly valued.

Triage or consultation nurses can assess a patient's physiological and psychological needs over the telephone and determine the appropriate course of action according to established protocols. The triage or consultation nurse typically will provide appropriate advice to patients, thereby eliminating unnecessary office visits. Or, the nurse may provide support to patients experiencing medical emergencies. When appropriate, the nurse may need to schedule an urgent care appointment with a member of the primary care team.

Nursing may free up the physician by providing advice to patients over the phone, communicating various lab and radiology test results to patients and triaging patient walk-ins. Nurse-only visits may be developed to perform blood pressure checks, administer medication, educate patients and perform other tasks within their scope of practice. ■

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Choosing Sides On HMO Rules

The Clinton administration has dropped plans to issue rules that would have restricted the ability of HMOs to reward doctors for limiting care to Medicare and Medicaid patients. The rules were designed to ensure that elderly and indigent members of the federal and state health programs were not denied needed care.

HMOs nationwide had complained, saying the rules would have required them to rewrite tens of thousands of contracts with doctors, according to The New York Times. The HMOs also said the government did not understand the importance of financial incentives in health care. Critics of such incentives said they create a conflict of interest for doctors.

Meanwhile, the AMA's House of Delegates voted to support legislation that would force doctors to disclose to patients when they have signed agreements with health plans that limit their ability to discuss financial incentives. Known as gag rules, these agreements are designed to prevent doctors from discussing the financial arrangements they have with health plans.

Comment: *HMOs in Massachusetts have bucked the trend by agreeing to support a bill that would limit the extent to which HMOs can use financial incentives to keep costs down.* ■

Oregon Doctors Form Physician-owned Practice Management Company

Three major Oregon physician group practices have reached agreement to merge, creating the state's first physician practice management company (PPM). The new entity, Physician Partners Inc., would be one of the nation's largest physician-owned and physician-governed PPMs. The PPM would be owned by physicians and its seven-member board of directors includes four physicians.

Based in Portland, Physician Partners Inc. will result from a merger of Corvallis Clinic, in Corvallis, Ore., HealthFirst Medical Group, of Portland, and the Medford Clinic, of Medford, Ore. Combined, the three groups employ more than 1,600 staff members, have more than 300 care providers, more than one million patient visits last year, and revenue of $170 million.

"This is the next logical step in the consolidation of health care delivery," said David Goldberg, president and CEO. "Physicians have been—and must continue to be—the most important element of health care delivery. But they have been the slowest to organize. Our job is to consolidate and manage the business aspects of health care delivery so that our physicians can focus on delivering high-quality care."

Comment: *The company plans to grow by acquiring primary care and multi-specialty physician group practices in Oregon and elsewhere. Physician Partners will be the first PPM to be based in the Pacific Northwest.* ■

MedPartners Acquires Multi-specialty Group

MedPartners/Mullikin Inc. has acquired Cardinal Healthcare, a multi-specialty group of 75 physicians in Raleigh-Durham, N.C. Cardinal provides services at 16 clinical facilities and 15 satellite locations and is affiliated with some 500 physicians through three IPAs. Although the IPAs are in the early stages of development, they have contracts with five managed care companies to provide health care to 6,000 enrollees. MedPartners/Mullikin operates in 23 states, providing prepaid health care to more than 800,000 enrollees in 45 HMOs.

Comment: *In just three years, MedPartners/Mullikin has grown to $4.4 billion in revenue, boosted recently by its acquisition of Caremark, one of the nation's largest managed care companies.* ■

Effect of Consolidation: Faster Music, Fewer Chairs

As a result of heavy consolidation in every segment of health care, only a few diverse large companies will survive in the 21st century, said Robert J. Hoehn, director of stock research at Salomon Brothers, investment bankers, in New York. The large companies that survive will eliminate all niche players unless those players have developed a substantial marketing advantage with an advanced product, he predicted.

Speaking at a conference titled "Faster Music, Fewer Chairs: Effects of Health Care Consolidation," Hoehn also predicted HMO market share, currently at about 23%, will reach 60% to 70% in the next seven years. HMOs are rapidly moving from simply obtaining discounts from providers and controlling utilization into full-scale providers that manage disease states. Doing so requires greater management skills, new partnerships, and information systems, all of which will separate HMOs from smaller competitors. As market-accepted standards of quality become available, reaching those standards will be required of all HMOs.

Comment: *Currently, the Health Plan and Employer Data and Information Set (HEDIS), developed by employers, HMOs, and the National Committee for Quality Assurance (NCQA), a health plan accrediting agency in Washington, D.C., is used widely by health plans and employers to measure health care quality. Consultants and health care organizations, however, are developing other quality measurement tools in an effort to grab market share.* ■

NEWS AND COMMENTARY

High Marks for Managed Care

A survey of 1,400 Medicaid recipients in New York City shows that those enrolled in managed care plans had better access to care and were likely to be happier with their care than those enrolled in a fee-for-service plan. In the survey funded by the Commonwealth Fund, a philanthropy in New York, the care of some 1,083 Medicaid participants enrolled in one of five managed care plans was evaluated and compared with that of some 410 patients in a traditional plan. Managed care scored well in almost every category, according to researchers who reported their findings in JAMA, July 3. The researchers found no evidence that the managed care plans were denying or delaying care.

***Comment:** Managed care has grabbed a large share of the New York market in a short time, and if patients are satisfied, financial success will follow.* ■

Small Companies Are Choosing HMOs

Small to mid-size companies are moving away from traditional indemnity plans in favor of managed care, according to a survey by insurance brokers Johnson & Higgins, in New York. Last year, 46% of companies with fewer than 1,000 workers offered a managed care plan, compared with 38% in 1994, the firm said. Over the same period, 28% of such companies contracted with HMOs, versus 22% in 1994.

Competition among HMOs and PPOs has allowed smaller employers to shop for the best price. In the 1980s, many smaller employers were facing health care cost increases of 10% per year. Last year, the average HMO cost dropped by 11.4% for small and mid-sized employers, the survey showed.

***Comment:** Given the growth of managed care, observers expect traditional fee-for-service plans to become increasingly rare.* ■

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

Our mission at *Physician Practice Options* is to be a practical information resource for physicians seeking to thrive in a rapidly changing health care environment. On 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 willingly make ourselves available to answer any and 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.

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Richard L. Reece, MD
Editor-in-Chief
15 Banbury Crossing
Old Saybrook, CT 06475-2362
860/395-1501
Fax: 860/395-1512
E-mail: RReece1500@aol.com

Joseph Burns
Editor
21 Stone Wall Lane
Falmouth, Mass. 02540
508/495-0246
Fax: 508/495-0247
JoeBurns@gnn.com

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