

# PHYSICIAN PRACTICE OPTIONS™

September 1997

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

## Multispecialty or Single-Specialty? Managed Care Drives Group Formation

**M**anaged care is designed to offer one-stop shopping to large health care buyers. In theory, purchasers are supposed to be able to contract with one health plan and get many services for workers, dependents, and retirees.

This practice influences physician group formation and development significantly. It leads specialists to join multispecialty groups to reduce overhead and to give them access to a referral base. One-stop shopping also induces primary care physicians (PCPs) to join other PCPs in single-specialty groups, again to reduce overhead but also to

allow them strength when negotiating with managed care organizations (MCOs).

"Managed care organizations seem to prefer groups that can provide a wide range of medical services," says Penny L. Havlicek, a consultant with the American Medical Association, who wrote a recent report on group formation patterns, *Medical Groups in the United States: A Survey of Practice Characteristics*. "As long as managed care persists, the environment would seem to favor multispecialty and family or general practice groups."

But this trend may be changing. A rising

number of MCOs are altering their procedures to allow plan members to use specialists without a referral from a PCP, and specialists are becoming more comfortable dealing directly with MCOs. Both of these developments lead specialists to form their own groups.

"More and more specialists are forming or joining single-specialty groups," says Walter Unger, founder of Walter J. Unger & Associates, in Laguna Niguel, Calif., health care consultants who advise physicians on group formation. "They usually do so for lifestyle reasons, to gain more freedom over their schedules and to protect their incomes." Small, single-specialty groups (those with two or three members) may lose market share and see a precipitous drop in income because MCOs would prefer to contract with larger physician groups that can serve large groups of plan members.

About 35% of the nation's physicians, or more than 210,000, are part of a medical group (see sidebar on page 7). In 1995, the most recent year for which numbers are available, about 70%, or 13,684, of the nation's approximately 20,000 medical groups were single-specialty groups, employing 86,094 physicians, the AMA says. Multispecialty groups make up about 22% of the market, or 4,388 groups, but employ significantly more physicians, 110,360. Family or general practice groups (employing no other specialists) compose the balance, in which 1,564 groups employ 9,000 physicians. The average size of multispecialty groups is more than four times that of specialty groups. Single-specialty groups average 8.2 physicians, while multispecialty groups average 25.4 physicians.

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## Columbia/HCA Investigation Offers Lessons for Physicians

Columbia/HCA built its \$20 billion empire partly on financial partnerships with physicians. Columbia's former chairman and CEO, Richard Scott, pushed limited partnerships for high-admitting doctors. Under Scott's theory, having physicians invest in Columbia hospitals would motivate them to admit and refer more patients to Columbia's facilities. These physician-investors were the bedrock upon which Columbia would expand, Scott reasoned. The trouble is, the bedrock began to crumble in March when more than 100 agents from the FBI, the Internal Revenue Service, and the federal Health Care Financing Administration seized billing records and other documents from about two dozen offices of physicians affiliated with Columbia/HCA in El Paso, Texas. Now, 700 federal agents are investigating Columbia's facilities in seven states. On July 25, Columbia/HCA's board forced two top executives, Richard Scott and David Vandewater, to resign. In his first decision, the new chairman and CEO, Thomas Frist, Jr., MD, ended the company's selling of ownership stakes in its hospitals to physicians.

## Five Most Apparent Lessons

What can physicians learn from this experience? The five most apparent lessons are

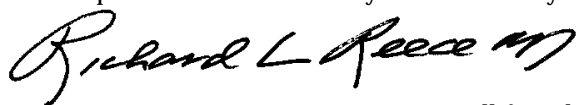
*Be cautious.* In deals with physicians, Columbia's have been unlike those of other hospital systems. Columbia owned many facilities in many regions, including hospitals, surgical outpatient units, and home health agencies. With this system, Columbia believed it could offer physicians an ownership stake in a regional health system and thus skirt laws forbidding direct referrals to doctor-owned facilities.

*Be realistic.* In competitive markets, collaboration between hospitals and physicians is necessary for the survival of both. At some time, you will negotiate with a local hospital on business issues. When you engage in a joint venture, make sure it is reviewed by a lawyer who represents you (not the hospital) and who has expertise in health care law. Remember that alliances between hospitals and physicians are complex and few definitive rules exist.

*Be aware of federal investigators.* Probes are likely on any ventures in which physicians have ownership interests and which involve Medicare payments; hospital-sponsored entertainment, promotional events, fishing trips, or educational events at resorts; buyouts of doctors' practices at above-market value; office rentals at below-market value; and excessive fees for committee assignments.

*Be protective of your reputation.* Affiliating with an aggressive organization could result in unnecessary disagreements, media exposure, and opposition from members of the community. Any controversy could undermine public and investor confidence in a physician venture and could stir opposition from politicians or regulators who may be looking for symbolic high-profile targets as examples of Medicare abuse.

*Be a strong patient advocate.* When necessary, complain to the board of directors of the hospitals with which you are affiliated or the board of directors if you work for a corporation. Let the board know when the quest for profit has harmed health care quality. It may be necessary to bring problems that threaten patient care to the attention of the media. Remember that health care professionals are entrusted with a responsibility to the public that requires professional conduct beyond that required in any other business. After all, studies have shown that physicians are among the most trusted professionals in our society. We are the only ones who can protect that trust.



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# Balanced Budget Act Creates Opportunities for Physicians, Hospitals Act Has Far-reaching Implications for All Providers

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

The Balanced Budget Act will foster dramatic changes in health care over the next few years. While the federal government will offer Americans a tax cut of \$263 billion, it will offset losses in income tax revenue by cutting \$115 billion from the Medicare program and \$13 billion from Medicaid.

These cuts will come in the form of lower payments to physicians, hospitals, and other providers over the next five years. The act also calls for increases in payments from some of the richest Medicare beneficiaries, and allows those enrolled in Medicare to get fee-for-service care if they wish to pay more for it. In addition to cutting the amount of money that goes to pay Medicare and Medicaid providers, the government also will foster the growth of managed care in these public programs.

One reason the legislation will drive the most dramatic change in health care since Medicare began in the 1960s is that it will shift Medicare and Medicaid beneficiaries from traditional fee-for-service medicine into managed care and stimulate competition among providers, says Michael Blaszyk, a hospital consultant in the Boston office of William M. Mercer Inc., health care consultants.

"It will be critically important for all providers to evaluate their alliances and operations to maintain a competitive position in their markets," says Blaszyk. "Managed care organizations, in particular, will need to evaluate the strength of their current position in the Medicare and Medicaid markets and determine their vulnerability to new forms of competition."

## Opportunities for Physicians

One significant feature of the act that will foster competition involves the creation of provider-sponsored organizations (PSOs). "For the first time, managed care organizations other than HMOs will have the

opportunity to contract directly with Medicare," Blaszyk says. Beginning in 1999, the act allows PSOs to contract with Medicare patients.

"PSOs will be licensed based on new federal solvency standards, which will be specifically designed to take into account the unique nature of a provider-owned delivery system," says Beth Morrow, an attorney with Mercer who specializes in health care law. "The inclusion of these new standards was an important victory for providers, who wanted assurances that they would not be subject to state insurance solvency requirements."

formed to deliver services through direct contracts with payers, PSOs also are called physician-sponsored networks (PSNs).

PSOs are significant entities because they allow physicians and hospitals to compete more directly with managed health plans for employer contracts. Currently, state regulations are a substantial barrier to forming a PSO because physicians and hospitals forming such organizations need to raise significant funds to meet the solvency requirements. In most markets, health plans have most or all of the patients enrolled in managed care organizations.

"Managed care organizations are willing to

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— Michael Blaszyk, William M. Mercer Inc.

To operate under the new law, a PSO would need to apply to state officials for a license. If state regulators failed to act on the application within 90 days, the PSO could apply to the federal government for a license. Providers had asked to forego the state licensing procedure, but state regulators protested. The National Association of Insurance Commissioners had said eliminating consumer protections built into state-licensing and capital requirements would threaten the stability of the health care system. Currently, insurance commissioners regulate health insurance activities in the states.

Developed and financed by physicians, hospitals, and other health care providers, PSOs often are defined as affiliations of providers that deliver health care services under contract with insurers, managed care organizations, or the government. Usually

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

Another way the act will stimulate competition involves raising payments to HMOs that care for Medicare beneficiaries in rural areas. Payments have been too low in such areas to attract HMOs.

"Taken together, these developments will spur enormous growth in managed care," Blaszyk says.

## Cuts in Compensation

The act also will cut spending dramatically. When compared with current spending,

payments to physicians will be reduced by about \$5.3 billion over five years, according to *Modern Healthcare*. These savings will come from using a single payment system. Currently, physicians are paid separately for surgery, primary care, and nonsurgical pro-

tight operating margin will place many hospitals in an untenable position. Hospitals will need to identify their strategic objectives and develop plans to minimize the effect of these reductions.”

Compared with current funding levels,

Jane Orient, MD. “We applaud Congress,” Orient says. “These two provisions are the first step to restoring seniors’ right to spend their own money in the way they see fit, just like anyone under the age of 65.

“Up until now, government bureaucrats have said they’ll decide how to ration care,” Orient says, “that seniors are too stupid or too feeble to decide with their doctors what medical care is best for them. This is an important and overdue acknowledgment that the government has no right to say, ‘You can’t spend your own money,’ even if it means saving your own life.”

Two groups that represent health care purchasers also are pleased with the Medicare reform measures. The U.S. Chamber of Commerce, in Washington, D.C., and the Healthcare Leadership Council, an organization in Washington, D.C., that represents purchasers and other groups, had formed the Coalition to Save Medicare. They praised the act because it increases consumer choice and competition in health care. In addition, the act keeps the Medicare hospital insurance trust fund, known as Part A, solvent until 2007.

One of the most important provisions of the act is a newly funded child health insurance program, Kid Care. Through this program, states will have the flexibility to determine how health care services will be delivered, and will choose from a menu of options to develop a standard benefits package.

“As states move quickly to implement their Kid Care programs, they’ll look to the health care industry to make comprehensive packages and, in some instances, direct services available,” says Morrow of Mercer. States will get \$24 billion in grants to buy health insurance directly, expand Medicaid, or buy health services from providers directly. About one-third of the total will come from increases in taxes on cigarettes. According to congressional estimates, some 2 million children would be covered under the program, about 20% of the number of uninsured children nationwide.

Much work remains to be done on Medicare, and the legislation establishes a new commission to address the challenge of providing for Medicare’s long-term future. In particular, Congress needs to be prepared to fund Medicare so that it can meet the needs of the Baby Boom generation as it approaches retirement age. ■

**“Many doctors would be happy to reduce fees or to treat a Medicare patient for free if it means keeping ‘Big Brother government’ out of the transaction.”**

**—Jane Orient, MD, Association of American Physicians and Surgeons**

cedures. This change will cut fees for surgical services by an average of 9.4%, but increase fees for primary care and nonsurgical procedures, *Modern Healthcare* said. The law also will move about \$390 million in spending on physician specialty care and surgery next year to primary care. In 2002, the government plans to spend about \$4 billion more per year on primary care at the expense of specialty care.

Although the act’s effect on physicians will be significant, hospitals will lose some \$39 billion in Medicare payments over five years. For example, Mercer says, the law will

1. Cut Medicare payments to hospitals, including those for diagnosis-related groups, capital projects, and graduate medical education.
2. Reduce Medicare and Medicaid payments to facilities that serve a large proportion of indigent patients (called disproportionate share hospital payments).
3. Slash Medicare payments to home health agencies, hospital outpatient departments, and skilled-nursing facilities by shifting from cost reimbursement to prospective payments.

“These cuts will force hospitals to evaluate how they do their core business, particularly for hospitals in which Medicare accounts for a significant part of their annual revenue stream,” says Blaszyk. Medicare pays for as much as 60% of all hospitalizations and 40% of all outpatient care.

“The commercial market has been successful in driving down payment rates over the last several years, leaving Medicare to emerge as the best payer in town,” Blaszyk continues. “Adding these reductions to a

Medicare growth in payments to managed care plans will be reduced by about \$22 billion and growth in payments to home health and skilled-nursing facilities will be cut by about \$28 billion, *Modern Healthcare* reported.

#### Reaction From Providers

Despite the cuts, provider organizations generally support the efforts by President Clinton and Congress to reshape Medicare, although many believe Medicare needs still more reform. The American Association of Health Plans, a trade group in Washington, D.C., said it supports efforts to strengthen Medicare, to offer beneficiaries wider choices, and to promote competition.

The Association of American Physicians and Surgeons Inc. (AAPS), a group in Washington, D.C., that represents physicians in all specialties, says it is pleased with the Medicare reforms in the act. In particular, AAPS is pleased with two provisions that allow patients greater choice. The first provision, called private fee-for-service, allows seniors to upgrade their health care coverage by supplementing Medicare’s payments with their own. The second allows patients and physicians to enter into private contracts for a mutually agreeable fee, without submitting a bill or asking for reimbursement from Medicare. This provision prevents the government from rationing care, protects patients’ privacy, creates savings for taxpayers, and may actually cost less for the patient, AAPS says. “Many doctors would be happy to reduce fees or treat a patient for free if it means keeping ‘Big Brother government’ out of the transaction,” says AAPS Executive Director

## COVER STORY

(Continued from page 1)

### Seeking Patient Volume

Rather than form their own groups or networks, specialists join multispecialty groups to get more patient referrals from PCPs, Unger says. This fact is especially true in markets dominated by managed care plans. MCOs often use PCPs as gatekeepers, in which a PCP must answer to an MCO when he or she sends patients to specialists. The MCOs likely provide financial incentives for not referring patients to specialists and may impose penalties for doing so. As a result, some specialists have seen the number of referrals from PCPs decline as managed care market penetration has grown. A drop in referrals usually accompanies a corresponding decline in income, Unger says.

To counteract the loss of referrals, many specialists have affiliated with PCPs in multispecialty groups, thus aligning their financial incentives with gatekeepers and allowing them to share in any profits. This strategy allows specialists to offset a decline in per-case income with an increase in net income through profit-sharing.

Traditionally, MCOs have preferred contracting with multispe-

**“Managed care organizations seem to prefer groups that can provide a wide range of medical services. As long as managed care persists, the environment would seem to favor multispecialty and family or general practice groups.”**

—Penny L. Havlicek, AMA

cialty groups because such groups offer a wide range of services under a single capitated contract. “Having to negotiate only one contract for a range of services is an efficient way to conduct business,” Unger says.

PCPs can enter into risk-sharing arrangements more easily than specialists because most of their income is from relatively predictable, inexpensive, and frequent unit costs, such as office visits. Therefore, they profit if fewer services are delivered and suffer financially if more services are delivered than had been anticipated.

Conversely, specialists’ costs are much more variable. Since specialists receive most of their income from expensive and relatively infrequent procedures, their financial risk is greater under capitated contracts. As a result, few managed care vendors have offered specialty care at capitated rates until very recently.

Even a comparatively small unanticipated increase in services provided under a pre-paid, capitated contract can mean a significant loss of income in an at-risk relationship. In addition, specialists receive a large amount of their income from Medicare, and Medicare reimbursement rates will fall significantly under the Balanced Budget Act of 1997 (see Commentary, page 3).

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“There’s no doubt specialists are feeling financial pressure brought on by managed care and drops in Medicare rates,” says

service basis,” Unger says. “But specialists are becoming more comfortable with capitation and are learning where they can get

They may need more sophisticated operational support and strategic planning, he says.

Moreover, pediatric groups have a market advantage with MCOs that gets lost in multispecialty groups, Kassan adds. “People choose their health plans based on whether their children’s doctors are in the plan much more often than they choose a plan based on where their own doctors are,” Kassan says. “HMOs without an affiliation with prominent regional pediatricians can’t do business. This is an untapped economic advantage to pediatricians, who we believe may not get proper value for their service within a market in multispecialty groups.”

**“There’s no doubt that specialists are feeling financial pressure brought on by managed care and drops in Medicare rates.”**

**—Terry Kane, MD, InteCardia**

William J. (Terry) Kane, MD, president of InteCardia, a physician practice management company (PPMC) in Chapel Hill, N.C., that specializes in developing managed care services for cardiologists.

### Changing Market Conditions

Another reason multispecialty groups are growing is because consumers are demanding broader access to specialists, forcing MCOs to question the use of PCPs as gatekeepers. Stephen Wiggins, chairman of Oxford Health Plans Inc., in New York, has said his company is developing capitated contracts with specialists. Oxford estimates that 75%, or \$1.7 billion, of the company’s \$2.2 billion in medical spending in 1996 went for services provided by specialists. “We’re asking primary care to control all of this,” Wiggins told *The Wall Street Journal*. “It’s getting complicated, and it’s something primary care doctors weren’t trained to do. We’ve come to the realization that the gatekeeping strategy isn’t working. It has its place, but it can’t be relied upon for expensive medical events.”

Such evolving market dynamics encourage specialists—even those in single-specialty groups—to develop the ability to enter into capitated contracts, Kane says. “They’re beginning to discover they can work well in capitated environments, that the technology exists to allow that to happen,” he adds.

One way single-specialty groups achieve the ability to handle risk-based contracts and develop relationships with MCOs is to affiliate with a PPMC capable of providing the expertise and information systems necessary to make such contracts profitable. “The large majority of single-specialty groups are still paid primarily on a fee-for-

the help to make managed care contracts work for them, too.”

Some specialists form single-specialty groups because of the demands of their practices, says Joel Kassan, vice president for regional development for Kelson Physician Partners, a PPMC in Bloomfield, Conn. In 1994, Kelson sold PPMC services to multispecialty groups. Last year, the com-

### Compensation Complications

One reason specialists consider single-specialty groups rather than multispecialty affiliations is the complexity of the compensation arrangements. It’s an issue that can produce considerable tension in multi-

Table 1: Sharp Growth in Group Formation

	1965	1995
Number of medical groups	4,289	19,787
Physicians in groups	28,381	210,811
Members in single-specialty groups	8,956	86,094
Members in multispecialty groups	17,141	110,360
Members in family/general practice groups	2,284	9,069

Source: *Medical Groups in the United States: A Survey of Practice Characteristics*, AMA, Chicago, 1996.

pany decided to market solely to groups of pediatricians, “and its been a bright road ever since,” Kassan explains.

Today, Kelson serves more than 100 pediatricians in single-specialty groups in Connecticut, Florida, Massachusetts, and New Jersey. “Because of the nature of their practices, pediatricians were not being well served in multispecialty groups,” Kassan says. “Pediatricians have high-volume practices, providing primarily ambulatory services only. They have no need to worry about managed Medicare reimbursements, a major concern of most multispecialty groups.”

Pediatricians in multispecialty groups also compete with internists and family practitioners for patients. Their needs differ from other doctors in those groups, says Kassan.

specialty groups, Unger says.

“Specialists like to work with people who think like they do and have the same financial goals,” says Kenneth Abramowitz, a health care system analyst with Sanford C. Bernstein & Co., an investment research firm in New York. “A lot of specialists look down on primary care physicians. They believe that they, the specialists, carry the multispecialty group financially and don’t receive their fair share of the compensation.”

Operational costs generally consume about one-half of a group’s revenue, Unger says. How revenue is divided in multispecialty affiliations can lead to disagreements, however. Specialists receive most of their income from single, expensive procedures. An interventional cardi-

## Study Shows Group Composition, Ownership Trends

The number of medical groups is increasing, and a rising number of physicians are joining or forming groups, according to the American Medical Association. In a report last year on group formation, *Medical Groups in the United States: A Survey of Practice Characteristics*, the AMA said that from 1965 to 1995, the number of medical groups rose by 361% (see table). From 1991 to 1995, the number of medical groups rose by 16.4% (from 16,576 to 19,787) and the number of physicians in groups grew by 14.3% (from 184,358 to 210,811).

The rate of growth in group formation has slowed since 1991, in large measure because of group consolidation, the AMA report shows. The report reflects consolidation by comparing 1984 and 1995 data. In 1984, groups with three or four physicians represented 54.8% of all groups, and 19.4% of all physicians. Also in 1984, groups of 100 or more physicians represented 1.1% of all groups and 29.4% of all physicians. By 1995, the percentage of groups with three or four physicians had fallen to 45.9% and the number of physicians in those groups had fallen to 14.7%, but the percentage of groups of 100 or more physicians and the number of physicians in those groups stayed about the same.

"These data indicate that there is consolidation among medical group practices," the report states. Although the number of practicing physicians is getting larger, within the market physicians are increasingly concentrated in larger groups, the report says.

The percentage of physicians in groups has grown significantly since 1965. In 1965, about 10% of the nation's 270,000 physicians were in groups. By 1995, that figure was almost 35%, about 245,000 of the nation's 700,000 physicians. Most of those physicians practice in multispecialty groups, which have always been larger, on average, than single-specialty groups. In 1965, multispecialty groups were almost three times larger, on average, than single-specialty groups. By 1995, they were four times larger, on average.

But single-specialty groups grew at a faster pace. Between 1965 and 1995, the number of single-specialty groups grew by 533%, multispecialty groups grew by 197%, and family and general practice groups grew by 140%. The number of single-specialty groups represented a larger proportion of all groups in 1995 (69.7%) than it did in 1965 (50.4%).

While there are more single-specialty groups than multispecialty groups, multispecialty groups are larger and employ more doctors. In 1995, single-specialty groups employed 41.9% of all physicians practicing in groups, and multispecialty groups employed 53.7% of all group physicians. Family and general practice groups

employed 4.4% of all group physicians. The mean number of physicians per single-specialty group is 6.2, while the mean number for multispecialty groups is 25.4. The average size of family and general practice groups is 5.6 physicians.

Most medical groups are small, however. About 46% of all groups are composed of three or four physicians. But even though groups of 100 or more physicians represent just over 1% of all groups, they employ 30.7% of all group physicians. Conversely, groups with three or four physicians employ only 14.7% of group physicians.

### Ownership Issues

Although the word "employ" generally applies to the relationship between groups and the physicians working in those groups (because groups usually set schedules for their members and often pay salaries and benefits), the physicians employed by medical groups usually have an ownership interest in those groups. About 95% of all medical groups, or more than 17,000, are owned by physicians. Of the remaining 5%, hospitals own 2.5%, management service organizations 0.9%, universities 1.4%, insurers 0.2%, and HMOs 0.9%. More than 97% of single-specialty groups are physician-owned, and about 90% of multispecialty groups are physician-owned. Interestingly, some 64.1% of groups with 100 or more physicians are owned by physicians.

About 78% of all groups, or 13,557, are legally organized as either professional corporations or professional associations. The next largest type of organization is a partnership, representing about 14% of all groups or 2,403 groups. The rest are organized as investor-owned for-profit corporations (2%), not-for-profit corporations or foundations (3.9%), or some other arrangement (2.3%). Of single-specialty groups, about 81% are either professional corporations or professional associations. Among multispecialty groups, 72% are either professional corporations or professional associations.

The report concludes that the number of physicians practicing in groups and the number of groups will continue to rise, but the way these groups practice is changing. As a result of the growing influence of managed care, medical group practices may evolve into or be consumed by integrated delivery systems, in which physicians, hospitals, and managed care plans are organized under one entity to provide a broad continuum of services.

Regardless of whether physicians organize as traditional medical group practices or as PPMCs or in some other organization, they will continue to consolidate their practices, the report shows.

ologist, for example, may perform four angioplasties and generate revenue of \$1,500 from each in a day. A PCP may see 30 patients in office visits a day, and generate revenue of \$100 for each. Thus, a cardiologist may generate twice the fee income as a PCP. The income disparity

results in complicated and often controversial compensation schedules. "The issue is usually handled through constant debate in multispecialty groups," Unger says. "Some group practice leaders say they have three compensation packages going at the same time: last year's, this

year's, and next year's," Unger adds.

PCPs sometimes react to the financial demands of specialists by forming their own groups that exclude specialists, says Michael J. Martin, MD, president of Advocates for Primary Care, a consultancy in San Francisco that advises PCPs on

(Continued from page 7)

group formation. "Specialists want as much of the premium as they can get," Martin says. "They are used to compensations that may not be realistic in today's health care market."

It is likely that specialists subsidize PCPs in multispecialty groups, comments Abramowitz. "But whether they can successfully handle capitation and secure referral sources on their own is still an open question," he adds.

### Multispecialty Advantages

Although compensation issues in multispecialty groups can cause dissension, economies of scale and increased referrals are significant advantages, says Unger. "Specialists have to look at many issues in making such a decision, such as whether affiliation with or membership in one multispecialty group will mean losing referrals from other groups or solo practitioners," he explains. "But such relationships can mean an expanded geographical base and an increased ability to handle managed care contracts. There is no one best way."

Multispecialty groups offer significant market advantages, says Abramowitz, and specialists should consider those advantages when deciding whether to affiliate with such groups or form their own. "Multispecialty groups offer a continuum of care, and that can result in the kind of cost savings attractive to managed care. As a result, they are better able to handle capitated contracts and manage outcomes," he says. "Multispecialty groups are better at cost containment, quality, and outcomes. Therefore, they're better for the market."

Like almost every other issue in managed care, deciding whether to affiliate with a multispecialty group or to form a single-specialty group should hinge on the needs of the market, Unger says. "Such decisions always depend on the circumstances of a local environment," he explains. "That includes the attitudes of the physicians with whom one is affiliating, the demands and practices of local payers, and the attitudes of any potential investors. The main concern for specialists should be the effect such a relationship could have on their current practice and referral patterns." ■

# Group Sees Changes After One Year With PhyCor

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

Two years ago, managed care enrollment was growing quickly in South Carolina. Many physicians in Columbia were fearful that managed care would dominate the market and limit their options, according to Michael Harris, MD, and Robert Callis, MD. Family practitioners, Harris and Callis were part of a 13-member group in Columbia at the time. Like physicians in many markets, they wanted to know how they could control their own economic destiny while also maintaining their professional independence.

In the intervening two years, Harris and Callis have succeeded in meeting their goals by affiliating with a physician practice

Medicaid recipients into capitated health plans. Columbia had several PPOs and five HMOs, none of which dominated the market, since HMO market penetration was less than 10%.

Last year, the Center for Studying Health System Change, an organization in Washington, D.C., said Columbia was feeling the effects of managed care growth. "Long accustomed to their roles, players in the Columbia, S.C., health care market now face challenges from outside ideas, outside concepts, and outside players," the center said in its *Community Snapshot Project*, which reports on local conditions as managed care enrollment grows. "Market participants have heard and read

**"We've had our growing pains, but the relationship has worked well. They've helped us form an IPA and they've come up with the capital to build an infrastructure that will eventually support 100 physicians."**

—Robert Callis, MD

management company, PhyCor Corp., in Nashville, Tenn., last year. In the year since, they have learned much more about the business side of their practice than they ever thought they would need to know. Here's a look at their lessons learned.

### Fearing the Worst

Harris, 39, and Callis, 47, began dealing with managed care plans in 1985, and by 1995, the group had about 8,000 capitated lives under care and was deriving about 25% of revenue from managed care. Since a substantial portion of the group's patients were in managed care plans, the members of the group believed it was time to become more savvy about managed care. They knew several out-of-state HMOs were considering a move to South Carolina because state officials were planning to enroll

about national changes in the way health care services are financed and delivered. They do not welcome such change coming to its market from beyond its borders, and they do not want such change to alter their long-practiced and long-held market roles. In an effort to keep up with health system reform, while preventing such reform from being forced upon them by outsiders, players in the Columbia market are taking tentative steps toward health system integration and managed care."

A city of 537,000 residents, Columbia has four major hospitals—Richland Memorial, Lexington Medical Center, Providence, and Baptist Medical Center—struggling to reduce excess capacity, which averaged 40% citywide. Over the past two years, the four hospitals have begun to form strategic alliances with each other, and

Columbia/HCA, in Nashville, has purchased Providence Hospital. To gain market share, the hospitals have been buying primary care practices and establishing centers of excellence for specialists. In turn, the specialists have been trying to decide if they should become partners with hospitals or with primary care physician groups. Recognizing that both the hospitals and the HMOs would need them, the primary care physicians decided to organize.

In September 1995, three groups merged. Callis and Harris' 13-member group of family practitioners, a group of five internists, and a group of eight ob-gyns formed the Carolina Primary Care Group. Almost immediately, the 26 members began to discuss the need for a capital partner. Some of the members favored making a deal with a hospital system and some favored working with a physician practice management company. After negotiating with several hospital systems and with PhyCor, the group agreed in April 1996 to sell its practice to PhyCor. This sale startled the community, which had a tradition of resisting outside influences. Today, the group has almost doubled in size to 46 physicians. In addition to 24 family practitioners, nine ob-gyns, eight pediatricians, and five internists, the group also has two physician assistants, five nurse practitioners, and five nurse midwives.

#### Down to Business

Following the sale to PhyCor, Harris and Callis were surprised by the amount and variety of new responsibilities. They had to work much harder on business matters, for example, than they had anticipated. In fact, they had expected business pressures would ease after the acquisition. Instead, both men became much more engaged in strategic planning, in reorganizing the group's staff, in hiring new physicians, in planning for expansion, and in determining what the group needed in order to grow. They were surprised, too, they said, by the amount of capital required—although they would not reveal how much—for information systems, hiring managers, improving accounts receivable, centralizing billing, and consolidating personnel into one location.

"It was a baptism into organizational politics," says Harris. "It was a time of high anxiety for all of us, and not all of our previous employees made the cut."

Seeking to cut costs, the chief administrator and an accountant were let go within six months of affiliating with PhyCor. After a year, the group cut the number of office managers from 10 to five.

"We and the PhyCor people had to get adjusted to each other's styles," says Callis. "We educated them, and they educated us. We thought our overhead would go down, and instead it went up. Adding ancillary services, such as laboratory and imaging devices, was much more complicated than we imagined."

One reason adding services was complicated is that PhyCor has a deliberate decision-making process. In order to add a service, the group needed to develop a business plan, including *pro forma* projections. "We were used to trusting our best guesses and

plunging ahead," says Harris. "If we wanted to set up a satellite clinic in a neighborhood, previously we had just gone ahead and done it quickly because we knew the neighborhood and we knew that a four-person group was just the right size for such a clinic. Generally, our best guesses were right, but PhyCor forced us to justify our assumptions. That took some getting used to."

**"It was a baptism into organizational politics. It was a time of high anxiety for all of us, and not all of our previous employees made the cut."**

**—Michael Harris, MD**

represent 50% of the business at one hospital. Our limiting factor right now is that we don't have enough primary care physicians to handle the load. We're looking for younger primary care physicians who want to be in an expanding group, and we want to add specialists, too, because we think the future belongs to multispecialty groups, not purely primary care groups. But adding specialists isn't easy because most of them are still doing well, which is a function of the local market."

In closing, Callis concludes that the relationship with PhyCor has offered substantial advantages. "We've had our growing pains, but the relationship has worked well," he says. "They've helped us form an IPA. They've come up with the capital to build an infrastructure that will eventually support 100 physicians. We believe we're now well positioned for the future." ■

Seeing Results

"In a year, we've been able to double our size," says Harris. "We now have 25% of the primary care managed care market share, meaning neither the HMOs nor the hospitals can ignore us. We have a dominant market presence in one of the two counties that make up the Columbia market, and we

#### Seeing Results

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# How Clinical Support Systems Could Change Medicine at the Point of Care

Experts predict competition in markets dominated by managed care will force physicians to adopt sophisticated information systems to help them make clinical decisions.

E. Harry Creasey, president and CEO of Kelson Physician Partners, a physician practice management company in Bloomfield, Conn., for example, has said information systems for clinical decision making are vital to the success of group practices and other physician organizations. The investment banking firm of Punk, Ziegel & Knoell in New York predicts that physician-driven computing will be the next wave of demand and growth in health care information systems. In particular, physicians need clinical decision support systems that help them make treatment decisions for individual patients at the point of care.

An expert on the topic is David M. Wesley, vice president of strategic product planning for Object Products Inc., a company in San Francisco that develops software to help physicians make clinical decisions. Wesley was the founder and president of Velocity Healthcare Informatics, now an operating subsidiary of Object Products. A leader in developing systems that allow providers to use data on patients' health status to measure outcomes, Wesley has designed information systems to assist providers in managing value. In general, value in health care is defined as care that is of the highest quality and delivered at the lowest justifiable cost. Clinical decision support and its role in value management are important for physicians building practices and groups that will be viable and competitive in the coming years.

## Essential Tools

Wesley predicts that within three years physicians in mainstream practice will begin evaluating and implementing systems for clinical decision support at the point of care. "They will quickly become an essential tool for any organization involved in health care delivery," he predicts. "Eventually, the use of

clinical decision support will be as common as the use of the stethoscope."

As managed care plans become more dominant and as purchasers focus more closely on quality of care, interest is intensifying in clinical decision support tools for physicians, Wesley says. Also, managed care plans and employer purchasing organizations are transferring financial risk to physicians. Under capitation and other risk arrangements, physicians are accountable for achieving quality and managing costs in order to optimize value. Therefore, physicians need sophisticated systems to price risk accurately and to manage care effectively.

"This trend reflects a renewed under-

alternative is to give responsibility and control back to physicians." The direct provider contracting strategies of many employers and business coalitions reflect this trend. (See "Minnesota Employers Elevate Physicians' Status by Eliminating Middlemen," July.)

Shifting accountability to physicians is but one of many changes in health care that are leading physicians to consider a wide variety of information systems to meet myriad needs. As such, physicians often are confused about which systems would be most appropriate for their practices. Physicians also are cautious about information systems because they are extremely expensive. The confusion and expense notwithstanding,

**"Physicians need clinical decision support strategies and systems to empower and assist them as they take on financial risk and accountability for value management."**

**—David M. Wesley, Object Products Inc.**

standing that the decisions physicians make in the process of treating patients are key determinants of costs and quality," Wesley explains. "Consequently, physicians need clinical decision support strategies and systems to empower and assist them as they take on financial risk and accountability for value management."

Risk and accountability are being shifted to physicians for several reasons. Seeking to stay competitive and to maintain their margins, health plans have to manage the underlying drivers of value: cost and quality, Wesley says.

## Shifting Responsibility

"Traditional, top-down medical management is reaching the limits of its effectiveness," Wesley explains. "We cannot accelerate the pace of cost reduction and quality improvement by continuing to micro-manage physicians from the outside. The only

Wesley says, clinical decision support tools may be the most important information systems physicians need today.

"Clinical decision support for physicians puts their decision-related information needs first," Wesley explains. "Physicians' decisions affect 75% of the health care dollar. So, the aim is to provide just-in-time, relevant information to support and guide physicians as they develop a plan of care for each patient. Under this model, financial, administrative, and documentation tasks would be derived automatically from the decision-making process, thus increasing physician efficiency. This view contrasts with traditional approaches, under which physicians are forced to use financial functions and financial data as their primary interface with information systems. At most, clinical decision support today is a back-room process not directly related to physicians in the actual process of care."

## Confusing Terminology

The term "clinical decision support" may be confusing because it refers to systems that do more than assist physicians in making clinical decisions at the point of care, Wesley cautions. "The term also applies to other systems, such as those used for retrospective data analysis to profile physician performance," he says. "Managed care plans use such tools to develop report cards that rate and rank physicians on their past utilization and cost patterns.

"In our approach, however, clinical decision support is intended as a front-line process that actively defines which data are critical in order to supply information specifically relevant to the case at hand, in real-time, directly to the physician," Wesley continues. "To be more precise, therefore, we might actually call it *clinician* decision support."

Unfortunately, clinical decision support also is confused with electronic health record systems, since both purport to provide the same basic functionality, Wesley explains. In general, insurers, health plans, and physician groups that need access to patients' records use systems that store and report electronic health records. "Basically, they are little more than computer-based patient recordkeeping systems that replace the current paper-based patient records," Wesley says.

The recently published *Comprehensive Guide to Electronic Health Records* (New York: Faulkner & Gray, 1997) reports that most of the new electronic systems basically mirror traditional paper-based records. "Essentially, all they do is introduce different technology for the traditional documentation process, substituting one documentation tool for another," Wesley explains.

Unlike simple documentation tools, clinical decision support focuses on using computer technology to give physicians information they can use in treating individual patients. Then, the data created in the process of care are used to establish documentation by building patient records, and feeding administrative transactions. So, the question is, What comes first: decisions or documentation? Despite some notable examples of progress in electronic health records, many physicians have been reluctant to use electronic systems just to have better access to the traditional chart.

"It is important for physicians and physician organizations to understand that the

two types of systems are distinctly different," Wesley continues. "By design, most electronic health records systems available today generally enforce an all-or-nothing implementation path," he explains. "Total, comprehensive system implementation is highly disruptive to physicians. Many early users of electronic health records are not realizing a level of benefit to justify the cost or the magnitude of the change required. Conversely, clinical decision support systems allow for evolutionary implementation, so that physi-

cal data as they measure and track outcomes have come to understand that information reported by the patient brings a vital new dimension that yields a more complete and useful picture of outcomes."

Physician practices also will soon discover the relationship between outcomes, care guidelines, and protocols in clinical decision support, Wesley predicts. "Both outcomes and guidelines are aspects of the same continuous-loop process. Care guidelines and protocols initially are formulated

**"Eventually, the use of clinical decision support systems will be as common as the use of the stethoscope."**

**—David M. Wesley, Object Products Inc.**

cians can set the priorities for applying information technology in such a way that a return on investment can be realized and measured for each step in the automation evolution." Physicians can start with outcomes management, for example.

Once a physician group recognizes the need for such a system, the next issue is the types of data to use. "Presenting physicians with all possible details overwhelms them," Wesley explains. "Giving them irrelevant information is inefficient and ineffective. Physicians want just enough of the right information to support decision making as they care for patients. They want a succinct view from which they can drill down for more detail. They require summary scales and scores and intelligent warning signals synthesized from various data sources, which will vary by case type and physician preference."

## The Value of Outcomes

Patient-reported outcomes will be a central element in clinical decision support. Today, a growing number of physicians and physician managers recognize the value and importance of patient-reported outcomes. Several outcomes management systems define and measure outcomes based on changes in patient-reported health and functional status, Wesley says. "Using patient-reported data brings the patients' perspective on their health and quality of life into the equation," he explains. "Care providers who use patient-reported data to complement clinical

using current medical literature and physician consensus combined with aggregated outcomes and process information. Once protocols and guidelines are implemented at the point of care, outcomes and process data are gathered and analyzed periodically to improve the guidelines and protocols. Ideally, this cycle never ends," he says.

Wesley believes clinical decision support systems have a logic and an inevitability to them. Yet, there are some basic implementation hurdles to overcome, he says. "Any information system implementation or conversion imposes costs and some culture change on targeted users," he explains. "Clinical decision support requires physicians to use information in a new way. Traditional system approaches, even in the clinical arena, are predicated on two-dimensional, fixed reporting as the primary mode of data use," he says, meaning that someone else uses the system and produces a report that may be given to the physician. "Clinical decision support, on the other hand, allows physicians and other providers to interact directly with information and analytical engines to predict which care steps will optimize health outcomes for individual patients," Wesley explains. "A successful implementation requires supportive medical directors and one or more physicians to champion the new technology among colleagues in order to demonstrate the payoff for truly using information to support clinical decision making at the point of care." ■

# Oxford Empowers Physicians by Educating Its Health Plan Members



**Benjamin Saferstein, MD,** is vice president of medical affairs for the New York region for Oxford Health Plans Inc., a managed care organization in Norwalk, Conn., that serves plan participants in Connecticut, New

York, New Jersey, and Pennsylvania. Oxford also has affiliated plans in Florida and Illinois. Saferstein trained in internal medicine at Mount Sinai Medical Center in New York City, in pulmonary medicine at Mount Sinai and at the Institute for Diseases of the Chest in London. Also, he worked for the National Health System for two years in Britain and has served in health systems in the United States, such as the Veterans' Administration, and in several academic medical centers. For 25 years, he was the chief of the division of pulmonary medicine at St. Michael's Medical Center at the New Jersey Medical School, in Newark. In addition, Saferstein works as an internist and as a pulmonologist with the Montclair Medical Group, in Montclair, N.J. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

## Second of two parts

**Q.** Dr. Saferstein, earlier you spoke about how Oxford has developed one system in which patients can see any physician and another system in which physicians work as part of specialty teams for particular diseases. How does a patient choose whether to go to a PCP or to a specialty team? Is it a process of self-selection or does the patient go through the PCP?

**A.** It's self-selection. Everything in this program is patient centered. But suppose a patient goes to a PCP and the physician says, "You know, I think you need to seek an orthopedist to replace your hips." So the patient goes to the orthopedist, gets x-rays, and sure enough, she needs a hip replacement. Now, since most orthopedists don't do hip replacements, the orthopedist writes to the PCP and says, "Dear Bob, your

patient, Mrs. Jones, needs a hip replacement. I recommend going to Hospital X."

In our plan, the PCP will have available in the Oxford roster a list of organizations that have care teams and the physician will share that information with the patient. If the patient has a good relationship with the physician, I hope the patient will ask the doctor, "Where should I go?" My patients would always ask me, "Where should I have my lung taken out? Where should I have my heart surgery?" We hope that the patient and the PCP and maybe even the referring specialist will have an opportunity to refer. Hopefully, this will be done on the basis of outcomes and reputation.

How often when a physician refers a patient for a hip or a knee replacement or a bypass surgery is that referral based on factual or evidence-based information? Managed care organizations (MCOs) are just beginning to do so. In the past, physicians would say, "Well, I know a physician at Columbia who is very good at heart surgery. I heard my plumber had it done by him, and he liked him." I can think of five or six times in my entire experience as an internist, over 15 years, where I referred patients for a hip replacement, and I didn't know where to send them. I didn't know that there were physicians who were doing 500 or 1,000 of them a year and had complication rates of only 2%.

We believe this is both a patient-centric and a primary-care-centric focus. Also, the information derived from these care teams will guide us in determining how we can change behavior so that many institutions can achieve the same level of outcomes.

**Q.** So, you're quite excited about this?

**A.** This is one of the most exciting programs that Oxford has ever introduced. It presents an opportunity for patients and physicians to raise the level of our ability to focus on evidence-based outcomes, quality, drivers of success, patient choice, and primary care education.

**Q.** Do you believe that directing patients to a quality physician in the first place,

based on the evidence, will save cost?

**A.** You bet. As a matter of fact, one of my early dictums was, "Send a patient to a doctor who knows what he or she is doing, and it'll cost you half of what it would otherwise. The best costs less." I believe the knowledgeable, well-trained physician is the heart of any delivery system, and that these care teams raise that level even further because they're reporting to expert panels composed of some of the best physicians in the area.

**Q.** You've asked these specialty teams to respond to a request for proposal (RFP), which in itself must be a demanding task, isn't it?

**A.** Very demanding. In some instances, the RFP is 15 pages long. But we have worked to reduce that length and we have teams of people on staff who will help physicians put together their integrated delivery systems and help them respond to the RFP.

**Q.** Does the RFP require the physicians get together to form a team?

**A.** Absolutely. As a matter of fact, we now have physicians approach us who have already gotten together as a team. Although this is a process that we are fostering, it has been around before we initiated it at Oxford. For example, we had global contracts with various institutions that had already organized cardiac surgeons with global rates and end-stage renal disease contractors with total capitation on members.

We believe that an integrated delivery system, in which anesthesiologists, radiologists, and so on collaborate in care giving, will lead to significant cost savings, provide the quality, and let them be in charge instead of us.

Physicians are organizing in three ways: through MSOs that help them form these organizations; through MSOs that are affiliated with hospitals or academic medical centers; and through independent practice associations (IPAs) in which groups of physicians are teaming up with each other. We also have groups of physicians who have no organization, but team up because they want to do so—to tackle breast cancer cases, for instance. They come to us for the administrative support, and we're providing

it through our contractors.

**Q.** *When this specialty team concept is fully implemented, how many conditions will be under its umbrella?*

**A.** By the end of this year, 50, and by the end of next year, 100. We now have 40 either completed or in the process of being completed. And we had only 25 about three months ago.

**Q.** *Let's switch gears a bit. There seems to be a movement to reform managed care that's sweeping the legislatures in many states. Some of the bills being considered relate to open access to emergency rooms and mandatory hospitalizations for vaginal delivery and breast cancer surgery. How has this managed care backlash affected Oxford?*

**A.** It hasn't really. Unfortunately, we often get lumped in with other MCOs. We have tried to separate ourselves from the rest of managed care, and I think we have succeeded. We never had gag rules. We never had mandatory stays or mandatory movements of patients in obstetrics. We certainly did not mandate length of stay for mastectomy. We have never believed in what I call, first generation utilization review (UR), which is heavy-handed micro-management. We didn't ask a neurosurgeon why he was opening up a patient's head simply to comply with criteria from a UR organization in some distant location. We've never been in that business.

I'm not surprised that there's a backlash. The managed care industry has riled physicians, and now through these legislative

happens to be called managed care, unfortunately. Through its programs, Oxford is creating patient-centric and physician-sensitive programs that improve the delivery integration and efficiency of care.

**Q.** *Are you saying that integrating resources is more important to Oxford than micro-managing specialists?*

**A.** Exactly. In fact, when it comes to our specialist program, we put our money where our mouth is. Which is exactly what we've asked the care teams to do. And from a payment point of view, there is no more paying for procedures à la carte. We'll pay a

taxes, which is not that much. As for our growth, we are growing about 75% a year, and our membership is now 1.7 million. I think we grew almost 80% last year.

Much of the credit for our success goes to people like Stephen Wiggins, the chairman who had a vision of providing high-quality service to our members as well as to our physicians, who listened to what doctors and members told him, enabling us to give both what they wanted. Most people are reasonable. We wanted to give them choice. We gave them choice. We didn't restrict networks to reduce profits. And because of that,

**"One of my early dictums was, 'Send a patient to a doctor who knows what he or she is doing, and it'll cost you half of what it would otherwise.' The best costs less."**

care team a certain amount of money up front for the entire procedure, and when the case is finished, we'll pay a few percentage points more to get information back from the physician involved.

No longer will each physician have to collect all the bills for the anesthesia, the cardiac care, or the hospital in order to report to us what the total cost was. And each time a doctor has to send a patient to see an anesthesiologist or a radiologist, for example, he or she won't have to get any special authorizations to make these refer-

people joined. In some years, our membership has grown by 80% to 90%. But we have had to stick our necks out.

The nurse practitioner alternative medicine effort, for example, has not been easy to sustain. It has taken much time and effort to explain it to physicians, medical societies, and our practitioners, but it is the right thing to do. Even though only 2% to 3% of our members would choose a nurse practitioner over a physician, we want to give them that option and make sure that the care they receive is as good or better than the care they would receive under another system. We're not doing this to save money.

Another reason for our success is we have the best information. We have educated our physicians by sharing with them information regarding utilization. We also teach them that we all have to live within budgets. All of us are constrained by certain financial issues. Also, we believe strongly that technological advances should be used, sparingly, if necessary, based on decisions made by knowledgeable and high-quality physicians.

Finally, I think our success comes down to the people in the company. I have never worked in an organization with more talented people than those at Oxford. Obviously, success attracts people with talent with multiple skill levels. That's true at Oxford. Our people and the people who work with Oxford are very special. That's my view. ■

**"We believe an integrated delivery system, in which anesthesiologists, radiologists, and so on collaborate in care giving, will lead to significant cost savings, provide the quality, and let physicians be in charge instead of us."**

efforts, we're beginning to make inroads to address that.

At Oxford, we believe in illness prevention and caring. We don't believe in gag rules and limitations. In any revolution there are peripheral extremists' views that should be mollified or changed, but what we're talking about, here at Oxford, is creating a new integrated delivery system, which

erals. This program takes out the micro-management of ill people. It eliminates the Draconian tactics in managed care and lets the physicians make the decisions.

**Q.** *Why do you think Oxford has been the darling of Wall Street? Your profits are higher than almost any other national firm.*

**A.** First, I don't think our profits are higher. Our margins are about 3% after

# Consolidation Trend Encompasses Both Single-Specialty and Multispecialty Practices

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

Physician practice management companies (PPMCs) continue to acquire physician groups at a rapid pace. In the 12 months ending July 7, PPMC's have announced an estimated 270 acquisitions, an increase of 25% from the 215 practices they acquired in the previous year. Increasingly, physicians need capital and management expertise to prosper in an environment dominated by large managed care and hospital organizations. Affiliating with a PPMC has become a viable means to provide them with both. As a result, more physician groups are affiliating with PPMC's.

## Acquisition Highlights

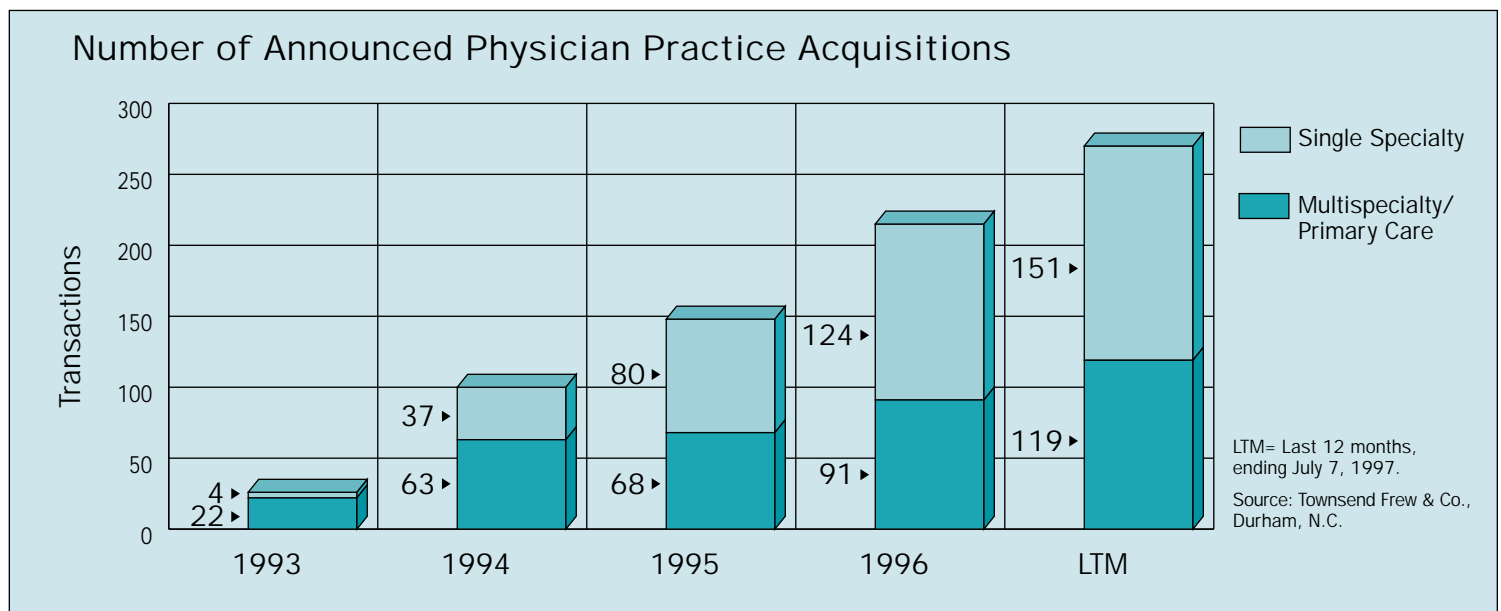
Many of the 270 announced acquisitions of physician practices were announced by the nation's three largest multispecialty PPMC's. MedPartners Inc., a PPMC in Birmingham, Ala., acquired Suburban Heights Medical

Center, a 56-physician multispecialty group in Chicago, on July 7. Financial terms were not disclosed. Also on July 7, MedPartners acquired Cardinal IPA, in Raleigh, N.C. Cardinal IPA includes 76 primary care physicians and 247 specialists and provides services to 15,543 capitated enrollees as well as fee-for-service patients.

PhyCor, a PPMC, in Nashville, Tenn., announced its affiliation with Welborn Clinic, a 93-physician multispecialty group in Evansville, Ind., on June 27. The clinic has its own 37,000-member HMO, which will continue to be owned by the physicians. With the acquisition, PhyCor now operates 48 clinics with about 3,370 physicians in 28 states. FPA Medical Management Inc., in San Diego, acquired Health Partners Inc., a private PPMC in Norwalk, Conn., on July 2 for \$115 million in stock. The acquisition gives FPA physician practices in several states in which it did not previously have

operations, including Kentucky, Ohio, and Virginia, and Washington, D.C. The acquisition is expected to add \$160 million to its 1997 revenues. Health Partners' previous shareholders included Oxford Health Plans Inc., a large managed care organization (MCO) in Norwalk, Conn., and WellPoint Health Networks, an MCO in Woodland Hills, Calif.

While the large multispecialty PPMC's continue to be aggressive in their strategies of affiliating with physician practices, more than half of all physician group transactions announced in the last 12 months involved single-specialty groups. Given the recent rise in the number of publicly traded single-specialty PPMC's and those that have recently filed for initial public offerings coupled with the high degree of fragmentation among many specialties, consolidation of single-specialty groups is expected to accelerate. ■



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## Oxford Agrees to Pay Interest to Physicians

As part of an agreement with New York Attorney General Dennis Vacco, Oxford Health Plans Inc., an HMO in Norwalk, Conn., has agreed to pay at least \$1 million in interest on claims from New York physicians and hospitals that have not been paid within 30 days. Although not subject to agreements with other attorneys general, Oxford said it would offer similar interest payments to physicians and hospitals in Connecticut and New Jersey. The policy will be effective for so-called clean claims—those with no inaccurate or incomplete information—paid on or after July 25.

The agreement between Vacco and Oxford, New York's largest HMO, should send a message to insurers that late payments would not be tolerated, state officials said.

In February, the New York State Medical Society and the New York State Society of Medical Oncologists and Hematologists complained to Vacco about late payments from managed care organizations. Payments to some physician practices were late by an average of four months, and several hospitals reported being owed tens of millions of dollars, *Newsday* reported.

Oxford said it paid slowly because it was upgrading its computers. Oxford Chairman Stephen F. Wiggins said the improved system helped Oxford pay over 91% of clean claims in June within 30 days. Oxford planned to pay all clean claims by the end of August, he said.

Peter Sullivan, executive vice president of the Nassau-Suffolk Hospital Council, a trade group of about two dozen nonprofit hospitals, said the agreement is a step forward, but he was concerned that limiting it to clean claims could allow the insurer to use technical issues to delay settling bills.

**Comment:** *Oxford said physicians, hospitals, or other providers with inquiries about the interest payment policy can call the company directly.* ■

## Two Practice Management Companies Aim at New York Market

Two companies have announced steps that will allow them to move more aggressively in the New York market, where managed care is growing.

In the first transaction, FPA Medical Management Inc., a managed care organization in San Diego, has agreed to acquire Health Partners Inc., a physician practice management company (PPMC) in Norwalk, Conn., for \$115 million in FPA stock. Announced in July, the merger will expand FPA's presence in Kentucky, Ohio, Virginia, and Washington, D.C., and serve as a platform for growth in New York, New Jersey, and Texas.

Health Partners has a network of 418 primary care physicians and 103,000 HMO members in New York.

In the second transaction, Complete Management Inc., a PPMC in New York, said it would spend \$12 million to acquire Consumer Health Network, a PPO in Piscataway, N.J. Consumer Health Network has 8,000 physicians providing PPO services in Connecticut, New Jersey, and New York.

**Comment:** *As managed care grows in New York, more companies are likely to become interested in acquiring physician practices in what is currently a huge, virtually untapped market.* ■

## Group of Physicians Protests For-profit Health Care

The Ad Hoc Committee to Defend Health Care, a group of Massachusetts doctors, wants to lead a nationwide physician response to its concerns regarding for-profit health care. Founded earlier this year by about a dozen physicians—including Bernard Lown, MD, a Nobel Prize winner who founded the Lown Cardiovascular Center in Brookline, Mass.—the committee has 2,200 physician members in Massachusetts and has raised about \$40,000, according to *The Boston Globe*.

"Our initial focus is a moratorium on for-profit takeovers," said Steffie Woolhandler,

MD, an associate professor of medicine at the Harvard Medical School and a physician at Cambridge Hospital, in Cambridge, Mass. "We don't mean just hospitals. We also mean health plans and doctors' practices."

For-profit ownership puts profit above patient care, she said. The group believes officials at all levels of government and in health care should debate the issues and set priorities that reflect the need to return to quality patient care.

**Comment:** *The committee plans to publish specific recommendations this fall in JAMA.* ■

## Columbia/HCA Names New President as Probe Continues

Jack Bovender Jr. was named president and chief operating officer of Columbia/HCA in August. Bovender succeeds David Vandewater, who resigned under pressure on July 25. On that day, Thomas F. Frist Jr. took over as chairman and CEO after forcing former Chairman and CEO Richard Scott to resign.

In March, the federal government

began investigating Columbia's physician affiliations, its Medicare billing practices, and its home-health referrals. Last month, 700 federal agents were investigating Columbia facilities in seven states.

**Comment:** *The changes at the top are not expected to slow the investigation, but new leadership may help minimize Columbia's exposure to civil and criminal penalties.* ■

## NEWS AND COMMENTARY

### Survey Predicts Continued HMO Growth

By 2000, employers expect to enroll nearly 40% of their workers in HMOs, the most restrictive form of managed care, according to a recent survey by William M. Mercer Inc., health care consultants in New York. At the same time, however, more employers will demand that HMOs provide high value and improved outcomes. Other surveys have shown that about 26% of workers currently are enrolled in HMOs, up from 22% in 1994. While enrolling more workers in HMOs, many employers also will offer workers a wider choice of managed care plans, Mercer reported. Some 22% of the 283 respondents offered a single health plan; just 13% expect to do so by the end of the decade, Mercer said. Among surveyed employers, the proportion offering an HMO in combination with a point-of-service (POS) plan is expected to rise from 5% to 14%, and the proportion offering an HMO and a PPO is expected to rise from 14% to 22%. Among the 197 survey respondents that currently offer an HMO, 86% rated access to care and geographic coverage as extremely or very important. Other criteria rated as extremely or very important were the cost of premiums (79%), member satisfaction (74%), financial strength (64%), reputation of networks (63%), and ease of doing business (59%). Some 84% of respondents monitor employees' satisfaction with health plans and make changes based on employees' comments. These changes frequently involve negotiating additional services (51%) or adding a new HMO (42%). Some 28% reported dropping one or more HMOs as a result of employee complaints.

**Comment:** *While many states are considering bills to limit the excesses of managed care, employers have shown that they prefer the most restrictive form of managed care, HMOs, which are consistently the lowest priced option among health plans. Conversely, traditional fee-for-service plans are the most expensive. By 2000, fewer than 10% of employees will be covered by fee-for-service plans, the survey showed. ■*

### 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:

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