PHYSICIAN PRACTICE
OPTIONS™

November 1997

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

Managed Care Forces Physicians to Focus Compensation Plans on Group Goals

CONTENTS

Features

Departments

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

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

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

Compensation issues are related to how physicians view medicine, Nuckolls explains. "The incentive under fee-for-service has been to keep everybody a little bit sick," he says. "Now, under managed care, we want to educate doctors and monitor their effectiveness in changing the behavior of their patients through, for example, smoking cessation programs, encouraging handrails on stairs for their elderly patients, and monitoring functional ability for chronic conditions. These are all part of delivering care. We want to encourage doctors to be aggressive about seeing that patients get the most effective care. We want doctors to think nontraditionally and to deliver services differently than they have in the past."

Carilion consists of 60 small medical groups, typically four or five primary care physicians (PCPs), practicing in 60 sites spread over 250 square miles in southwestern Virginia. The practitioners and groups are divided into five geographically based regions, each with its own medical director and practice manager.

Nuckolls and his colleagues at Carilion are re-examining how their members are being paid. Although managed care penetration is low in western Virginia, Nuckolls expects the market to change soon.

(Continued on page 5)

> **"Physicians who were used to being paid for piecework now have to learn how to think in terms of controlling health care costs as a group. That is creating tension among physicians."**
> **— James Nuckolls, MD, Carilion Healthcare Corp.**

EDITORIAL

New Column Debuts on Legal Issues

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

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

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

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

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

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

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

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

Richard L Reece MD

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

Toll-free phone: 888/457-8800
Fax: 860/395-1512
E-mail: Rreece1500@aol.com

Physician Practice Options is published monthly by Premier Healthcare Resource, Inc., Parsippany, N.J.

Publisher
Premier Healthcare Resource, Inc.
888/457-8800
E-mail: phrinfo@aol.com
Publishing Address: Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

Editor
Joseph Burns
508/495-0246
E-mail: joeburns@capecod.net

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

West Coast Patient Satisfaction Survey Reports on Physician Performance

A recent survey of patients is one of the first published polls to focus on the performance of physician groups not health plans. The survey of patients focused on 58 physician groups in California, Oregon, and Washington state.

The survey is another step in the evolution among the many imperfect systems designed to measure health care quality. Health care purchasers are developing these systems because they want to provide consumers with useful information that will help them to choose among physicians and health plans and because they are concerned that their focus on cost control has caused quality to deteriorate.

"In the past, most satisfaction surveys looked at member satisfaction with their health plan," says Walter J. Unger, principal of Walter J. Unger & Associates, health care consultants in Laguna Niguel, Calif. "While that's been helpful, satisfaction with physician performance is where the rubber meets the road."

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

Consumer Preferences

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

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

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

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

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

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

"Most satisfaction surveys have looked at member satisfaction with health plans, but satisfaction with physician performance is where the rubber meets the road."

— Walter J. Unger, consultant

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

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

(Continued on page 4)

(Continued from page 3)

The Importance of Quality

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

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

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

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

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

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

The Physician Value Check Survey Methodology

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

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

PBGH and TMQC sent more surveys to individuals aged 50 to 70 than to younger individuals to increase the likelihood of detecting changes in health and functional status over time. Of the 1,000 enrollees in medical groups, 700 were drawn from among those aged 50 to 70, and 300 were drawn from those aged 18 to 49.

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

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

The survey covered four areas:

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

Satisfaction issues included access to care (such as office hours and accessibility of physicians after hours); promptness of care (such as length of time waiting to see a physician); cost of care (such as amount paid out-of-pocket); technical quality (such as thoroughness of treatment and amount of time a physician spent with the patient); communication (such as whether procedures and the use of medications were explained adequately); courtesy of staff; and overall satisfaction with physicians.

(Continued from page 1)

> **"A meaningful compensation package does not produce shot-gun medicine; that's what costs money. Careful medicine tied to a team approach is the most effective medicine."**
> **— Bruce Haga, West Florida Medical Center Clinic**

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

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

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

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

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

A New Dynamic

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

(Continued on page 7)

Determining Compensation: A Typical Plan

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

Base Salary

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

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

Productivity Expectations

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

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

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

Incentive Program Design

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

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

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

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

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

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

Group expectations. Group expectations can include such contributions to the medical group as work attendance and punctuality, meeting attendance and participation, and professional presentations. A physician's performance in these areas can be evaluated by administrators, including the medical director.

> **"Under managed care, we want to educate doctors and monitor their effectiveness in changing the behavior of their patients by, for example, encouraging handrails on stairs for their elderly patients, or monitoring functional ability for chronic conditions. These are all part of delivering care."**
>
> **— James Nuckolls, MD, Carilion Healthcare Corp.**

(Continued from page 5)

aged care in which they receive a per member per month fee may be at financial risk for the cost of delivering care to these patients. Many medical groups, therefore, tie physician compensation and bonuses to how well the group performs.

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

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

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

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

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

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

Multispecialty Groups

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

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

(Continued on page 8)

Table 1: Typical Productivity Standards

Group	Patient visits per week
Family practice	120
Internal medicine	105
Pediatrics	130
Occupational medicine	140

Source: Findley Davies Inc., Toledo, Ohio, 1996.

Table 2: Targeted Productivity Levels

	Practice setting	Time to meet productivity target
New resident	New practice/new patient base	Two years
	Established patient base	Up to two years
Experienced physician	New practice/new patient base	Two years
	Established patient base	One year
	Acquired patient base	Productivity level over two years prior to acquisition

Source: Findley Davies Inc., Toledo, Ohio, 1996.

Physician Salaries Rise, According to One Survey

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

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

Another survey shows that medical groups are becoming increasingly dependent on managed care for revenue. In a survey last year by the American Medical Group Association (AMGA), in Alexandria, Va., managed care represented the fastest-growing source of revenue for group practices, but fee-for-service still accounts for more total income. Managed care's share of total revenue paid to physicians in 1995 rose to 31%, up from 27% in 1994. The fee-for-service share of compensation fell to 44% from 45% in the same period. The amount of group income from Medicare fell to 25% from 27% between 1994 and 1995, according to the AMGA.

Physician Net Income After Expenses and Before Taxes

Results of surveys conducted in 1995 and 1996 of nonfederal physicians providing patient care ($ in thousands)

Category	1994 mean ($)	1995 mean ($)	Percentage change (%)	1994 median ($)	1995 median ($)	Percentage change (%)
All physicians	182.4	195.5	7.2	150	160	6.7
General/family practice	121.2	131.2	8.3	110	124	12.7
Internal medicine	174.9	185.7	6.2	150	150	0.0
Surgery	255.2	269.4	5.6	219	225	2.7
Pediatrics	126.2	140.5	11.3	110	129	17.3
Ob-gyn	200.4	244.3	21.9	182	200	9.9
Radiology	237.4	244.4	2.9	220	230	4.5
Psychiatry	128.5	137.2	6.8	120	124	3.3
Anesthesiology	218.1	215.1	-1.4	200	203	1.5
Pathology	182.5	209.4	14.7	152	185	21.7
Other	158.2	188.5	19.2	150	170	13.3
Employment status						
Self-employed	210.2	230.8	9.8	176	199	13.1
Employee	148.2	152.6	3.0	130	136	4.6
Independent contractor	168.5	155.5	-7.7	140	155	10.7
Census region						
Northeast	171.1	192.7	12.6	140	155	10.7
North central	189.3	194.8	2.9	160	160	0.0
South	192.8	203.7	5.7	160	170	6.3
West	172.7	187.0	8.3	150	160	6.7

Source: Socioeconomic Monitoring System, AMA, Chicago, 1996.

(Continued from page 7)

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

"There is often a tremendous diversity in the perceived value of production. The most common unit of service for primary care physicians is office visits, which are comparatively predictable, inexpensive, and frequent. Specialists receive most of their income from expensive and relatively infrequent procedures. Thus, a cardiologist may generate twice the fee income as a PCP. The income disparity causes complicated and often controversial compensation schedules.

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

—Carson Dye, Findley Davies Inc.

"The difference in productivity standards between PCPs and specialists in multispecialty groups usually leads to nearly endless debate," Unger says. "As a result, compensation packages may change annually." ■

AMA's First Woman President Says Physicians Should Adopt a Wider Role in America's Health System

Nancy W. Dickey, MD, is president of the American Medical Association. The first woman to be elected president of the nation's largest physician organization, Dickey is a board-certified family physician from College Station, Tex. She also is the program director for the Brazos Valley Family Practice Program associated with Texas A&M University in College Station. A graduate of Stephen F. Austin State University, Dickey received her medical training at the University of Texas Medical School at Houston. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. *Dr. Dickey, in your family practice residency at Texas A&M University, what advice do you give the young men and women in that program and what do they ask of you?*

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

Q. *How important is it for physicians to form and join groups? Is that an important strategy in helping physicians meet the demands of managed care?*

A. In the markets where managed care has grown to the point that you have to negotiate contracts in order to have a busy practice, you certainly enhance your ability to negotiate if you're speaking for a large group of people, rather than just one. It's important for physicians in markets in which 50% or more of a population is enrolled in managed care, in which hospital systems compete aggressively, or even in areas where fairly large groups of physicians already exist to consider the advantages and disadvantages of forming collective bargaining units or clinics of their own.

There are some real advantages to forming groups. If you buy in bulk, you buy cheaper. If you are able to share space, you may be able to cut overhead, which makes you a more competitive provider of health care. But each physician has to look at the personal advantages and disadvantages of group formation. Each must decide if he or she wants to be a solo practitioner, in a group of two or three, or in a large integrated group of some kind.

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

A. Before physicians join an organization they have to ask what the purpose of that organization is: Is its goal is to free up a physician's time so that more time can be spent caring for patients? Is its goal to enhance the quality of care that's given? If, after reading the agreement, the physician sees that these goals can be achieved, then joining such organizations has the potential to be very positive. But if the primary goal of a physician management company is to show physicians how to increase the bottom line without improving the quality of care, physicians need to look at that organization carefully, perhaps even with a somewhat jaundiced eye.

> **"If the primary goal of a physician management company is to show physicians how to increase the bottom line without improving the quality of care, then physicians need to look at that organization carefully, perhaps even with a somewhat jaundiced eye."**

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

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

When it comes to using guidelines to improve the quality of care, physicians should be right in the middle of forming the organizations to do this work and of measuring the results of medical care. Physicians need to understand, however, that any quality-improvement system or any good clinical pathway clearly needs to say that at any point a physician's judgment can override the pathway. For physicians to sign contracts that force them to follow

(Continued on page 10)

(Continued from page 9)

"cookbook medicine" rather than to use the judgment they've been trained for is certainly not the best quality of care and probably borders on being unprofessional.

Q. *It seems that there are holes in the systems used to measure quality in the sense that many of these systems have been based on patient satisfaction surveys and on compliance with data from the Health Plan Employer and Data Information Set (HEDIS) [from the National Committee for Quality Assurance, in Washington, D.C.]. How can physicians contribute to establishing practical clinical criteria?*

A. One way they can do so is to support and participate in the AMA's American Medical Accreditation Program, which began operating last year and which will capitalize on improvements being made in clinical information systems. It's going to use not only the tools that are currently being used, such as HEDIS and patient satisfaction data, but there will also be two components that deal with the process of care and outcomes of care. Physicians are beginning to get the hang of how to answer questions about whether they're doing the best job that can be done, and they're getting the hang of how systems measure and evaluate their practices. Once they understand how these systems are used to evaluate them, they can make changes in their diagnostic or therapeutic practices. Later, they will want another measurement tool to evaluate their new performance.

Now is the right time to have a physician-driven quality measurement system, and the technology makes it feasible today. I'm not sure if it was doable 10 years ago. If the development of these systems is physician driven, or if physicians have an opportunity to offer meaningful input, these systems will deliver meaningful information to patients, to payers, and to others. Some of the other quality measurement systems, such as HEDIS, have been developed by asking: What can we measure? After recognizing that patient satisfaction can be measured, we've begun to measure that extensively. We're just not sure whether patient satisfaction has much to do with quality of care.

Q. *And, what do you think of the current quality measurement systems?*

A. New information systems will make it much easier for quality measurement systems to be developed and to be utilized efficiently. Until now, when everybody was using paper charts and the patient might have one in his family doctor's office, one in his orthopedist's office, one in his cardiologist's office, and one in two different hospitals in town, it was difficult to track care, outcomes and decision making.

Q. *Probably the single most visible criterion of quality is board certification. Physicians who are not board certified often call me to complain that this criterion is unfair. They were raised in an era in which board certification was unimportant, and they say that at least 150,000 physicians are not board certified. As managed care grows and as HMOs seek to contract only with board-certified physicians, this trend is threatening the livelihood of physicians who are not board certified. Is the exclusion of physicians who are not board certified an important issue and, if so, how do we address it?*

A. AMA's policy is that board certification is very important, but should not be the only criterion used. Whether it's the opportunity to get hospital privileges or an HMO contract, physicians should be evaluated on a variety of criteria, including demonstrated competence, training, and experience. Board certification should be just one of many measures.

We also know, however, that the final measure of a new physician leaving graduate school—board certification—has been one of the standards used to determine quality of care in this country. While we recognize that there are physicians who are not board certified but who are nonetheless extremely competent physicians, we question the process used to measure quality. If you don't have a good measure of what makes a competent physician, then you use the best available information. One way to do that is to suggest that, if you're board certified, you have at least jumped through the hoops defined by your profession. To young physicians today, I think the message must be extraordinarily clear: Board certification is important and you ought to pursue the appropriate training and certification processes in order to have that ticket.

Q. *It's been said that physicians respond positively to three things: education, financial incentives, and prompt feedback of relevant information regarding their performance. Given these criteria, physicians will do the right thing. Do you agree that physicians will respond positively given the right circumstances in most cases?*

A. Yes, they will. They generally want to do the right thing. When given feedback about what the right thing is, in the judgment of their peers or in terms of patient outcomes, there's reasonably good evidence that the majority of physicians will change or correct those things that appear less acceptable. Obviously, we are a group of varied individuals, just like any other group of 600,000 people. Within our ranks, just as in other similar groups, we have members who ignore such feedback.

"For physicians to sign contracts that force them to follow 'cookbook medicine' rather than to use the judgment they've been trained for is certainly not the best quality of care and probably borders on being unprofessional."

Q. *Managed care requires doctors to acquire capital in order to compete. Yet, since physicians typically are not used to accumulating capital to reinvest in their practices, the AMA has created a capital division to assist them. What is the status of that division and what is the intent?*

A. The intent of the initiative is to assist physicians in identifying sources of capital and then presenting a business plan to people interested in investing in health care. Basically, the initiative involves providing a list of phone numbers and an introduction, if you will.

The department also assists physicians who want to write a business plan. The plan may be to form a group or to develop a shared cooperative arrangement with other physicians. But the goal is to write a business plan that will tell potential investors why the plan is a good deal.

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

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

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

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

Q. *Another phenomenon is the shift from a system that once used primary care gatekeepers almost exclusively to a system that allows access to broad panels of specialists. This trend is a form of HMO backlash in that it's consumer driven. Is this patient demand for access and choice of doctors an important change?*

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

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

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

But the bottom line is that patients should have the right to decide which system they have and which one they want to pay for.

Q. *Some observers say we ought to have health insurance that allows more consumer choice, such as medical savings accounts. What is the AMA's position on medical savings accounts?*

A. We feel strongly about medical savings accounts and believe in allowing choice of expenditures. Texas Republican Senator Phil Gramm says that if he were to buy groceries the way Americans buy health care, he would buy groceries very different from the ones he buys now. He says that if someone else were picking up the tab every time he went through the line, he could afford to feed his dog T-bone steaks instead of dog food. Over the last 30 years, our insurance has moved to a system in which the employer pays most of the health care premium. The premiums are frequently first-dollar coverage; that is, an insignificant or no co-payment, no out-of-pocket payment. There is very little motivation for the patient to care or to understand what the costs of things are. Medical savings accounts put that back in perspective, but they do what insurance was originally intended to do.

They protect the individual who might have a catastrophic expenditure. So, they are a wonderful choice for lots of people, particularly the frugal users who would benefit personally because they, rather than the insurance plan, would get any savings that accrue from their efforts at managing their health. The good thing about medical savings accounts is that they create a real incentive for patients to be concerned about how they use their health care dollar because the winnings and losings come out of their own pocket.

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

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

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

Antitrust Rules Govern Group Practice, Network Formation

By Edward B. Hirshfeld, JD

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

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

Group Practice Formation

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

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

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

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

Market Concentration

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

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

Generally, each of the boarded physician specialties is considered a separate product market, although multispecialty product markets have been defined when more than one specialty provides the services in question. The geographic market is generally defined as the patient drawing area for the merging physician groups. These areas are usually small, no more than a 15- to 25-mile radius around the physicians' offices, depending on specialty.

A merger that increases the HHI and is prosecuted by federal regulators is not necessarily illegal, and might be successfully defended if it is prosecuted. In fact, a good defense may deter prosecution. The merging parties are free to show factors other than size that would prevent the merger from having an adverse effect on competition: for example, the merger might achieve efficiencies that enable the physicians to deliver higher quality care at a lower cost. Or, new participants, such as a physician management com-

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

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

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

Network Formation

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

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

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

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

The physicians may not communicate with each other about or agree on the fee levels. Each physician may preauthorize the messenger to accept from payers offers that fall within a fee range acceptable to the physician. The messenger may then create a schedule showing the percentage of physicians who would accept an offer at a given fee level and may present the schedule to payers. The messenger may enter contracts with payers on behalf of the physicians who have authorized acceptance at fee levels offered. The messenger must forward offers to all other physicians for consideration. Each such physician must decide individually whether to accept the offer, and the messenger may not influence the decision. Messenger-model networks are generally not subject to size limits because there are no fee agreements among the physicians. Size limits may be imposed if the network physicians agree about other issues, however, including non-fee-related contract issues, such as utilization review procedures, and the medical protocols that they will demand.

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

Substantial financial risk is defined as capitation, percent of premium arrangements, fee withhold arrangements, incentive plans in which physicians are rewarded or penalized based on performance in comparison to a predetermined budget, and global fees. Other forms of risk sharing also may suffice.

Clinical integration is best understood as the bundle of management techniques designed to coordinate the care of physicians to achieve a better value. Clinical integration can be achieved if the network implements an active and ongoing program to evaluate and modify physician practice patterns and to create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. Such management of practice patterns can include mechanisms to control utilization, selectively choosing physicians likely to further the goals of controlling costs and ensuring quality, and the significant investment of human and monetary capital in the infrastructure necessary to realize these goals.

Size Guidelines

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

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

Editor's note: To get a copy of the 1992 Horizontal Merger Guidelines *or the* 1996 Statements of Antitrust Enforcement Policy in Health Care, *readers may visit the Web site of the Antitrust Division of the U.S. Department of Justice at gopher@justice.usdoj.gov or http://www.usdoj.gov, or write to:*

Gail Kursh
Director, Health Care Task Force
Antitrust Division
U.S. Department of Justice
Constitution Avenue and Tenth Street, NW
Washington, D.C. 20530.

PPMC Growth Fuels Capital Markets

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

As the need for capital to fund expansion and build infrastructure for physician organizations continues to grow, it is fueling activity in the capital markets for physician practice management companies (PPMCs). Since June 30, five PPMCs have filed for or completed initial public offerings (IPOs); two PPMCs have filed for secondary equity offerings; one has filed a shelf registration; one has completed a private placement; and one has completed two debt offerings. Combined, the 10 companies are raising $1.2 billion (see Table 1). Despite the sometimes turbulent market for PPMC stocks, PPMCs are on track to raise over $2.4 billion in 1997, 30% more than they raised last year.

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

Of the existing 40 publicly traded PPMCs, the majority are single-specialty PPMCs. And, as more specialists feel the effects of managed care, more single-specialty PPMCs are being formed to help them succeed in a dynamic market environment that requires more capital. Today, there are 24 publicly traded single-specialty PPMCs, whereas there were only 17 at the end of last year. What's more, of the five PPMCs that have filed for or completed IPOs since June 30, all are single-specialty PPMCs: Three are dental practice management firms; two focus on eye care and pathology. With more PPMCs filing for public offerings, investors are likely to become more discriminating in choosing where to put their money. The companies that will attract that capital will be those that distinguish themselves from their competitors through acquisition growth and superior operational ability. ■

Table 1: Recent Offerings by Physician Practice Management Companies

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

Source: Townsend Frew & Co., Durham, N.C., 1997.

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

Hospital Executives Predict Managed Care Trends

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

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

The survey results show the following:

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

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

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

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

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

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

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

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

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

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

Automakers Say Cost Control Has Failed, New Approaches Needed

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

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

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

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

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

NEWS & COMMENTARY

Government Cuts Residency Programs

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

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

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

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

TOLL-FREE LINE FOR PHYSICIANS

888-457-8800

PHYSICIAN PRACTICE OPTIONS is a practical information resource for physicians making the transition to managed care.

In the search for new practice options, physicians are asking a variety of questions, including:

- *What's the value of my practice?*
- *Should I sell my practice and to whom?*
- *How do I educate myself to deal with managed care?*
- *What are my career options?*
- *How do I evaluate my organizational options?*
- *Where should I go to get capital?*
- *How can I make my practice more profitable?*

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

To reach us, readers are invited to call toll-free: ***888-457-8800.*** *The service is free to readers.*

Richard L. Reece, MD
Editor-in-Chief
PHYSICIAN PRACTICE OPTIONS

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE — November 1997

Premier Healthcare Resource
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

Sponsored by an unrestricted grant from **Bayer Corporation, Pharmaceutical Division**