

PHYSICIAN PRACTICE OPTIONS™

December 1997

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

Single-specialty Networks Help Physicians Gain an Edge Under Managed Care

CONTENTS

Features

Commentary

PhyCor-MedPartners Deal Raises Questions for Physicians Considering PPMCs 3

Interview:

Risk-based Contracting Opens Opportunities for Specialists 8

Departments

Editorial

Assessing Our 1997 Predictions 2

Health Care Law

A Look at the Legal Implications of Physician-hospital Relationships 12

Capital Ideas

Venture Capital Investment in Health Care Slows 14

News & Commentary 15

Specialists have suffered under managed care, in part because primary care physicians have been valued as gatekeepers. By controlling access to specialists, primary care physicians (PCPs) have kept costs down, cutting deeply into specialists' income in many markets.

Recently, however, specialists have been empowered by two trends that have helped to raise their value. In one trend, some plans are allowing patients to go directly to specialists without prior approval because managed care plans have found PCP gatekeepers can alienate patients.

The second trend involves the formation of single-specialty physician networks (SSPNs). A relatively new organizational strategy, SSPNs are being formed by specialists seeking to contract successfully under managed care and to maintain and to expand their patient base, according to a new report.

These networks tend to be started with little capital and are usually formed and led by one or two physicians who have strong business skills and experience with managed care, the report says. Moreover, physicians in these networks often share the financial risk of delivering care, a developing trend among specialists in many disciplines (see "Risk-based Contracting Opens Opportunities for Specialists," page 8).

"If the measure of success is getting managed care contracts, these entities are working," says Thomas M. Gorey, president and CEO of Policy Planning Associates, consultants in Crystal Lake, Ill. A lawyer, Gorey and his firm conducted extensive research into the formation and operation of SSPNs for the report, *Case Study Analysis of Single Specialty Physician Networks*. Gorey and Nancy K. Bannon, a lawyer and consultant with Policy Planning Associates, wrote the

report. "The success of these networks appears to demonstrate a sense of specialist empowerment that was not evident in the market five or six years ago," Gorey says.

Defined as "a business entity formed and owned by physicians in the same medical specialty in order to pursue managed care contracting opportunities and other cooperative ventures," SSPNs operate independently or in cooperation with a hospital or other entity, the report says.

To examine these networks in depth, Gorey and Bannon chose seven to research as case study examples of the trend. These seven networks represent a broad cross-section of SSPNs and were located in a variety of areas, Gorey says. At each of the organizations, 10 major areas of interest were examined:

1. Physician leadership,
2. Capitalization,
3. Strategy development,
4. Membership,
5. Governance,
6. Administration,
7. Contracting,
8. Physician payment,
9. Quality assurance and utilization management, and
10. Information systems.

Physician Leadership

The most notable common element among the SSPNs studied for the report was the presence of a strong physician leader who helped form the organization, the study showed. "Most of the organizations studied were spearheaded by one physician. The other members put a lot of faith in that doctor's experience with managed care, and with his or her business experience, as well," Gorey says.

These physician leaders have strong inter-

(Continued on page 5)

Assessing Our 1997 Predictions

At the end of last year, we made 10 predictions for this year (see "What to Expect in 1997—Ten Predictions for Physicians," December 1996). Keeping our promise to report on the accuracy of those predictions, we offer the following accounting of them, scored on a scale of 1 to 10, in which 10 means our prediction came true in a measurable way.

1. Multispecialty Groups Will Rise. We said health care executives would recognize that multispecialty groups are the core of the delivery system. They did not become the core this year, although they are likely to in the coming years. Score: 5.

2. Physician Groups Will Grow. We predicted that physicians would continue to move into groups in great numbers. According to the AMA, the number of physician groups nationwide that consisted of more than 25 physicians in 1996 more than doubled in 1997—increasing from 991 to 2,000 groups. Score: 10.

3. MSOs Will Win Favor. MSOs linked with integrated delivery systems and IPAs will become the favored organization for physicians, we said. The number of MSOs surpassed 2,000 this year, rising from 1,200 last year, but hospital-owned MSOs are proving ineffective and PPMCs prefer to acquire more tightly integrated groups. Score: 5.

4. PPMCs Will Continue to Grow. Some 30 PPMCs had issued public stock by the end of 1996; 10 more did so this year, bringing the total to 40. If market conditions remain favorable, another 40 may do so within the next few years. Score: 10.

5. Managed Care Will Grow by 8%. HMO enrollment growth likely will outstrip 8% this year since it grew by 10% in 1996. Precise numbers are not yet available. Our score: 8.

6. Businesses Will Cut Costs. We said buyers would drive down HMO premiums. Although health care cost increases remained lower than the rate of inflation for the fourth consecutive year, HMO premiums edged up slightly and many analysts predict an increase of 5% to 10% in 1998. Our score: 0.


7. Chaos Will Reign. "Market forces will foster cataclysmic changes in previously insulated markets," we said. Upheaval reigned in some cities in the East, such as Pittsburgh, Philadelphia, and New York, but we were mostly wrong on this one. Score: 2.

8. PSNs Will Rise. The Balanced Budget Act of 1997 contains provisions allowing provider-sponsored networks (PSNs) to form. Score: 10.

9. Specialists Will Drive Disease Management. Specialists have enjoyed a Renaissance of late as health plans have recognized that disease management requires specialty care. (See "Single-specialty Networks Help Physicians Gain an Edge Under Managed Care," page 1, and "Risk-based Contracting Opens Opportunities for Specialists," page 8.) Score: 10.

10. HMOs Will Bow to Consumers. HMOs catered to consumers by eliminating primary care gatekeepers and by offering wider access to specialists and more options, such as coverage for alternative medicine. Score: 10.

An average score of 7 leaves us room to improve the accuracy of our predictions for 1998, which we will report in the next issue.



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

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Michael B. Guthrie, MD, MBA
Executive Vice President, Director
Center for Clinical Innovation
Premier, Inc.
San Diego

Edward B. Hirshfeld, JD
Vice President
Health Law Department
American Medical Association
Chicago

Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co.
Physician and Hospital Consultants
San Diego

Paul Keckley
Chief Executive Officer
PhyCor Management Corp.
Nashville, Tenn.

Peter Kongstvedt, MD
Partner
Ernst & Young
Washington

Richard Lilledahl, MD
Health Care Consultant
Milliman & Robertson, Inc.
Seattle

Lee Newcomer, MD
Chief Medical Officer
United HealthCare Corp.
Minneapolis

James B. Nuckolls, MD
Chief Executive Officer
Carilion Healthcare Corp.
Roanoke, Va.

Brooks G. O'Neil
Managing Director
Piper Jaffray, Inc.
Minneapolis

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

Carl Schramm
President
Greenspring Advisors, Inc.
Towson, Md.

Jacque Sokolov, MD
Chief Executive Officer
PSO Development Corp.
Los Angeles

W.L. Douglas Townsend Jr.
Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

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

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

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

PhyCor-MedPartners Deal Raises Questions for Physicians Considering PPMCs

By Richard L. Reece, MD, editor-in-chief

Over the past several years, managed care has demonstrated that bigger is better. Larger companies, whether they operate hospitals, health plans, or physician practices, have more clout in markets dominated by managed care. That trend was evident again this fall when PhyCor offered to buy MedPartners to create the largest physician practice management company (PPMC). PhyCor and MedPartners are the nation's two largest PPMCs.

If consummated, the deal would create an organization large enough to negotiate with HMOs and hospitals as equals. But the merger also raises questions for physicians affiliated with either company, or considering an option to join a PPMC.

Since the two companies are so different, the announced combination was a surprise, says W.L. Douglas Townsend Jr., managing director and CEO of Townsend Frew & Co., in Durham, N.C., investment bankers that represent physician groups in strategic negotiations. Townsend also is a member of the Advisory Board of *Physician Practice Options*. "PhyCor and MedPartners were two very distinct and different operating and philosophically driven companies that happened to compete in the same industry," Townsend says. "PhyCor has been a highly focused and disciplined company, with a centralized approach to development and an emphasis on affiliating with multispecialty groups in secondary markets. MedPartners has had a more decentralized approach to market development, concentrating on larger urban markets and acquisitions across multiple delivery systems. With less than 10% of the nation's physicians affiliated with PPMCs, one would have presumed there was plenty of future growth opportunity for both of these organizations as independent entities."

Brooks O'Neil, managing director and senior health care analyst for Piper Jaffray Inc., investment bankers in Minneapolis, believes managed care was one of the

strongest forces behind the deal. "One of the main drivers of the deal, particularly from PhyCor's point of view, is that MedPartners has significant relationships with some of the fastest growing HMOs in the United States, and has substantial expertise at providing care in a managed care environment," O'Neil says. "The merger creates an organization that has physician concentrations in three states: California, Florida, and Texas. It also has significant senior populations, fast-growing HMOs, and sophisticated HMO organiza-

combined entity would be dealing with a single large company, which will try to meld different management styles in the coming months, many physicians may prefer to deal with smaller companies.

"There'll be a significant number of physicians who will choose not to be part of such a large company," O'Neil says of the combined entity. "On the other hand, the forces affecting health care today are relatively irreversible, and doctors who don't get involved with a large organization that has sophisticated, professional management

"PhyCor and MedPartners were two very distinct and different ... companies that happened to compete in the same industry."

—Douglas Townsend Jr., Townsend Frew & Co.

tions. Now there is one physician organization that will be able to sit down at the table as an equal in negotiating rates and in determining the care management for the enrollees in plans."

The Effect on Physicians

If approved, the merger would affect physicians in a variety of ways. Primarily, it would narrow their choice of potential PPMC partners. Out of the 45,000 physicians who are currently affiliated with PPMCs, about 21,600 are affiliated with PhyCor and 13,340 are affiliated with MedPartners.

MedPartners is most active on the West Coast, PhyCor in the East and Midwest. MedPartners' greatest presence is in major metropolitan areas; PhyCor is strongest in markets with as many as 250,000 people. The combined company would be bigger and would have as much as 20% of the market for physician services in some areas. Such size could help it restore clout to physicians negotiating with health plans.

Since physician practices owned by the

and managed care expertise are going to have a difficult time competing in health care in the future."

The merger may in fact strengthen the physician management industry. PPMCs currently serve only 7% to 8% of physicians who could be affiliated with or consolidated into PPMCs, meaning there may be a significant opportunity for new PPMCs to enter the market. Also, some executives at MedPartners or PhyCor may lose their jobs in the new organization and choose to form their own PPMCs.

"There will be an enormous explosion of small to intermediate-size physician practice management companies, focusing on very specific niches, such as oncology, ophthalmology, and emergency room medicine," says Jacques Solokov, MD, president and CEO of PSO Development Corp., of Los Angeles, and a member of the Advisory Board of *Physician Practice Options*. "I believe there will be an increased focus on PPMCs that can help physicians bear financial risk. Obtaining

(Continued on page 4)

(Continued from page 3)

capital for a business plan that includes physicians and hospitals, particularly physicians accepting risk, has been received very favorably on Wall Street.”

PPMC Hazards

The merger demonstrates a hazard of being acquired by a PPMC: The company you sell to may not be the company that later owns your practice. The Friendly Hills Medical Group, in La Habra, Calif., for example, had been affiliated with the Loma Linda University Medical Center, in Loma Linda, Calif. Friendly Hills was acquired by CareMark International, in Northbrook, Ill., about three years ago. It then became part of the MedPartners system when CareMark merged with MedPartners last year. With the PhyCor merger, Friendly Hills would have its fourth affiliation in recent years.

In addition, many physicians who became affiliated with MedPartners in recent years had heard presentations from both MedPartners and PhyCor, among others, and chose to sell to MedPartners. Administrators for these physician groups signed 40-year contracts, expecting to remain with MedPartners for the working lifetime of the physicians involved. Now that these clinics will become PhyCor affiliates, the physicians may feel as if they were mere commodities rather than long-term partners.

“Clearly, when two major players merge, it could potentially limit opportunities for physicians who may be considering doing business with those companies,” says Townsend. “PhyCor and MedPartners will no longer be competing for these relationships. We believe it will create a significant growth opportunity for some of the smaller PPMCs as physicians seek wider ranges of affiliation opportunities.”

While potentially reducing the number of options for physicians in the near term, the PhyCor-MedPartners deal also creates a degree of uncertainty around PPMC stock. After all, if the nation’s largest PPMC felt compelled to sell to a smaller rival, what does that action say about the value of its stock?

“It remains an open question whether this PPMC behemoth will do well on Wall Street,” says Townsend. “Investors may be

The Deal at a Glance

PhyCor, the nation’s second-largest physician practice management company (PPMC) with 1996 revenue of \$1.5 billion, will acquire the much larger MedPartners, which had 1996 revenues of \$4.8 billion. For each of MedPartners’ 200 million outstanding shares, PhyCor will swap 1.18 shares of its common stock, a trade valued at \$6.98 billion. In addition, PhyCor will assume about \$1.2 billion of MedPartners’ debt and issue about 236 million shares of stock, company officials said. PhyCor Inc. is in Nashville, and MedPartners Inc. is in Birmingham, Ala.

Expected to be final by the end of the first quarter of next year, the merger will bring together in one company 35,000 physicians and two companies that had \$6.3 billion in combined revenue last year. The boards of the two companies have approved the deal. It is still subject to approval by shareholders for both companies and by state and federal regulators. PPMCs acquire or affiliate with physician groups and provide management services, usually for a share of the group’s future income.

Joseph Hutts, PhyCor’s chairman, president, and CEO, will hold those same titles at the new company, according to *The Wall Street Journal*. The merger “creates the most compelling physician organization in the country,” Hutts told *The Journal*. “It will give doctors the tools and resources they need and the strength to stand as an equal with the large hospitals and HMOs.” The resulting economies of scale will enable the merged company to cut costs, Hutts said. The physicians of both companies operate in all 50 states and represent about 5% of the nation’s more than 700,000 physicians.

“I was surprised by the amounts involved,” comments Brooks O’Neil, managing director and senior health care analyst for Piper Jaffray Inc., investment bankers in Minneapolis. “But both companies have enjoyed a great deal of success as independent companies, and we believe they will continue to enjoy success for a long time into the future. It is a very powerful combination.”

The deal shows the importance of PPMCs today, O’Neil says. “Ultimately, physicians should control both the quality and the cost of health care, but physician organizations, particularly small practices or small groups, do not have the scale or sophistication to take advantage of the opportunity to manage care,” explains O’Neil, a member of the Advisory Board of *Physician Practice Options*. “Therefore, physicians and physician groups are realizing that they need professional management and expertise in managed care to be successful. At the same time, managed care companies are realizing that they need to contract with sophisticated physician organizations, which ultimately will manage the care.”

nervous about the potential earnings, especially in the short term, resulting from the merger of two such divergent cultures.”

In any environment, affiliating with a PPMC is a gamble. Physicians need to decide who can manage their practices more effectively: the physicians themselves or a more diverse management team from a large company. They also need to decide which is the better source of capital: a local bank or hospital or a publicly traded company operating out of town and beholden to investors.

The problem for physicians is that failing to affiliate also is a gamble. As managed care

dominates more markets, physicians need the marketing strength and negotiating clout that come with affiliating with a large company—as PhyCor and MedPartners decided—as long as the merged entity is successful over time.

“It will obviously be important for this merged company to be successful over the long term, to continue to drive the growth of physician practice management companies,” O’Neil concludes. “Long-term success is very possible for this merger given the strength of management and the quality of the organizations that are coming together here.” ■

COVER STORY

(Continued from page 1)

personal and organizational skills, are persuasive, decisive, and willing to make decisions that may be unpopular, the study said. The physician leaders commit significant amounts of time to the organization and assume several roles simultaneously, often including president, medical director, and network administrator. They are not usually compensated for the time they spend in these roles, but they do hold substantial equity positions in their organization, the report says.

Generally, these physician leaders understand how to identify market needs, and often have an existing relationship with a health plan or an independent practice association (IPA), which plays an important role in helping to win business for the network initially, the report says.

The experience of the physician leaders means network members often are willing to defer to the founder's judgment and accept the founder's strong leadership role, Gorey says. Nevertheless, the lead-

"The success of these networks appears to demonstrate a sense of specialist empowerment that wasn't evident five or six years ago."

—Thomas M. Gorey, Policy Planning Associates

ers may need to persevere considerably to overcome members' resistance to managed care. "As a practical matter, in most cases, physicians who do not agree with the vision of the organizer usually do not join, or they eventually leave," the report says.

Capitalization

Typically, SSPNs are formed with modest amounts of capital, making them attractive to physicians. The networks can meet their goals with a minimum investment, largely because their goals may involve achieving little more than simply obtaining managed care contracts, Gorey says. The networks keep costs down by avoiding lengthy planning processes, and by seeking legal and consulting expertise only after members have formed a basic organization and have developed a marketing strategy.

The networks studied for the report required physician contributions ranging from \$500 to \$6,000. Contributions of \$1,000 to \$2,000 were most common.

"A number of networks minimized capital requirements because individual physicians in the networks absorbed many of the incidental costs, such as legal fees and meeting costs, associated with formation," the report says. "Modest capitalization of most specialty networks also means that a significant amount of organizational work must be done by the physicians leading the formation process."

An exception to the general rule of modest capitalization was seen in SSPNs that created management service organizations (MSOs) to manage networks, which required significantly more capital to begin operations. That money was usually obtained through loans. When compared with SSPNs, MSOs provide much more sophisticated and expensive management services, such as

(Continued on page 6)

SPECIAL INVITATION TO SUBSCRIBE TO PHYSICIAN PRACTICE OPTIONS™

A one-year subscription to **Physician Practice Options**, (12 issues) regularly \$220, is now, for a limited time—\$110. **A savings of 50% off** the regular subscription price.

Simply send the attached card or remove the order form below to begin your subscription and get the information you need to succeed in health care. There's no need to send payment now, we'll gladly bill you next month!

Our editorial focuses on:

- Moving from fee-for-service to capitation
- Looking at practice valuation
- Finding strategic partnerships
- Marketing and expanding your practice

Please send form below to:

Physician Practice Options.

PO Box 3000

Denville, NJ 07834-9218

or, for faster service, please call toll free:

888/457-8800

Fax orders: 973-316-5989

Yes! Please send me a one-year subscription (12 issues) to **Physician Practice Options**

Name _____

Address _____

City _____ State _____ Zip _____

Please fill in the following information:

Bill me Payment enclosed

Medical Specialty: _____

Title: _____

I'm in a: Solo Practice Group Practice

If sending payment, please make check payable to: Physician Practice Options



Physician Practice Options

A Practical Resource to
Succeed in Health Care

billing, claims processing, and provider scheduling.

Contracting

SSPNs market themselves to payers by emphasizing quality of care and by claiming they have superior expertise to that of competing multispecialty groups, the study says.

Those SSPNs that are the first to develop in a market for a given specialty have a decided advantage, Gorey says. Early entry into a market may mean networks can negotiate capitation fees based on current fee-for-service rates, rather than on what would likely be lower fee-for-service rates in the future. It also enables networks to forge long-term relationships with payers before competitors emerge, the report says.

The first contracts with a payer can be

risky, however, because limited or inaccurate utilization data can make calculating payment rates difficult, the report says. Payers can be HMOs, health plans, insurers, or other physicians in medical groups and IPAs that accept financial risk from payers. When IPAs and medical groups are the primary payers, the relationship for services and the risk for those services usually will be with the primary care medical group.

Reimbursement

SSPNs pay physician members 85% to 90% of the revenue received from payers. SSPNs may receive payments from HMOs and other payers on a per member per month (PMPM) basis, but most networks pay physicians on a contracted fee basis, sometimes calculated in relation to Medicare rates.

When computing payments to physicians, for example, many specialty networks consider a physician's utilization levels and the relative values of the services provided. A common approach is to assign relative value units (RVUs) to each procedure.

At a number of networks, the reimbursement level floats up or down monthly, depending on the total number of RVUs network physicians charge in a given month. Some SSPNs have a physician steering committee that reviews RVUs regularly. The committees can increase RVUs for any given procedure but, because networks usually have fixed revenue pools, such an increase would be at the expense of payment for other procedures.

Several SSPNs have payment arrangements in which physicians are organized into small risk-sharing groups, formed so that the participating physicians can manage utilization and risk concurrently. Under these arrangements, RVUs for billed services are totaled each month for each risk-sharing group. If a group has a disproportionately high number of RVUs relative to other risk-sharing groups and relative to that of other months, its payment for that month may be lower than it would be for physicians in groups with fewer RVUs. In this way, payments to physicians depend on whether their particular risk-sharing group is "utilization efficient," the report says. Conversely, if utilization increases sharply as a result of an epidemic, a group might lose money.

Management Issues

On the issue of physician membership, the report says SSPNs generally are composed of a selective group of like-minded physicians who market themselves as providing high-quality patient care through a network of small, private practices. These networks tend to have a streamlined governance structure in which the network's founder often operates as a benevolent dictator. Not surprisingly, SSPNs seek to minimize administrative expenses so they can maximize payments to member physicians.

Quality assurance and utilization management activities typically evolve over time in response to demands from payers and to the needs of the network. Disease management, in which physicians focus on improving the quality of care while containing costs for a particular condition, is emerging as an

A Look at Seven Single-specialty Networks

In addition to describing how single-specialty physician networks (SSPNs) are formed, a new report on SSPNs focuses closely on seven networks in particular. The eight sponsoring organizations made recommendations to the authors of the report, Policy Planning Associates, health care consultants in Crystal Lake, Ill., about which SSPNs should be included in the study, and seven were chosen to represent a cross-section of medical disciplines and a broad geographic base. The report describes the history of the seven networks and outlines their current operations. The seven SSPNs studied are:

- **Atlantic Urological Associates**, in Daytona Beach, Fla. This network has six urologists out of the area's total of 11 urologists in four mid-sized central Florida cities. Some 36% of the population is enrolled in managed care in the Daytona Beach area.
- **The City of Hope Oncology Network**, in Duarte, Calif. This network has about 80 physicians, including 20 radiologists, serving a six-county area where 90% of the population is enrolled in managed care. The network was formed in 1995.
- **The Georgia Dermatologic Network**, in Atlanta. This 110-member group serves 20 counties in which 30% of the population is enrolled in managed care plans. When the network was formed in 1994, 65 physicians paid a \$500 one-time membership fee.
- **Imaging Associates of Colorado**, in Englewood, Colo. This radiology network serves Denver and surrounding towns where about 60% of the population is enrolled in managed care plans. Formed in 1995, the network has about 80 members, and subcontracts to other radiology networks.
- **Pediatric Subspecialty Network**, in Dallas. This network has about 60 pediatric subspecialists and was formed in 1995. A core group of 16 physicians contributed \$1,500 each to cover legal and other costs when forming the network.
- **Specialists in Plastic Surgery**, in Houston (see sidebar, "What It Took to Form a Plastic Surgery Network").
- **Vivra ENT Specialty Partners**, in Plantation, Fla. Vivra ENT has about 95 of the 160 otolaryngologists in a five-county area in South Florida. Some 30% of the population in the five counties is enrolled in managed care plans. The original network was formed as an IPA in 1990. In 1994, the IPA was acquired by Vivra Inc., a company in San Mateo, Calif., that manages specialty networks.

Case Study: What It Took to Form a Plastic Surgery Network

Specialists in Plastic Surgery (SPS), in Houston, is a 21-member single-specialty network formed in 1995. Founder Neal Reisman, MD, explains that by forming a network, members could be free to do aesthetic surgery, research, and teaching while the network sought managed care contracts.

"We were founded with the overall philosophy that as specialists we would have to deal with managed care in this market, but did not want to be consumed by it," Reisman says.

The network was organized as a nonprofit, limited liability partnership (LLP). The original 11 physicians paid \$650 each to form the network and agreed to provide services under SPS contracts, but they did not want to share office services, ownership, or control. The LLP structure offers protection from liability for the acts of other network members; it allows multiple types of entities, such as solo practices, professional corporations, and business corporations, to contract with the network; and it could be organized quickly and inexpensively. Being a lawyer and a physician, Reisman kept legal costs low by doing much of the legal work himself.

A plastic surgeon for 18 years, Reisman owns 90% of the partnership and another physician owns the remaining 10%.

To form the network, the physicians found they needed to resolve one significant issue, Reisman says. Many of the original 11 physicians were concerned about the percentage of their practices that would be devoted to providing managed care services. In addition to participating in managed care, members wanted to maintain and to grow their own practices, meaning they wanted to maintain independence.

"I do not want to be a managed care physician," Reisman says. "I don't want it to be 100% of my practice. I want a nice mix of aesthetic and cosmetic cases, selective reconstructive cases, and other types of cases in which I have an interest."

To resolve the issue, the network promised to increase the number of physician members. Today, there are 21 physician members. A contract for 250,000 covered lives would require the services of two or three full-time plastic surgeons. By expanding the

number of physicians agreeing to provide services under the contract, the physicians could limit the proportion of their practices devoted to managed care. To join the network today, a physician would pay \$1,000.

The network charges each physician an administrative fee of 10% of collected payments. This fee covers network overhead, which is about \$3,500 per month. Overhead costs are low because Reisman's office serves as the administrative headquarters, the network has only one full-time employee, and it purchases services, such as billing, from a vendor.

Contracting

SPS has two managed care contracts, one with a local multispecialty clinic that has a contract to provide care to 180,000 covered lives, and one with North American Medical Management, a multispecialty IPA in Houston that provides care to 100,000 covered lives. Under the first contract, SPS physicians see the clinic's HMO patients, other patients under the clinic's care, and patients who are aligned with the clinic through direct employer contracts. In Houston, about 80% of the population is enrolled in some form of managed care plan.

After SPS signs a contract with a payer, it contracts with members of the network to provide services. SPS physicians also have contracts independent of the network, either individual agreements with HMOs or through other contracting entities.

Payments to SPS physicians are based on a fee structure or relative value unit. Payers typically pay the network within 90 days of when service is provided. The network pays each physician based on the physician's billings, minus the 10% administrative fee. Physicians retain any money paid as a copayment.

The network offers member physicians significant advantages, Reisman says. Being a member helps physicians to reduce their overhead and to increase efficiency. It also allows member physicians to gain increased exposure to managed care and increased negotiating strength. At the same time, they are free to do the work they prefer to do.

important strategy for networks.

As they become successful, many specialty networks will begin to seek to expand their activities. "To expand in scope, however, will require more substantial capitalization, more significant administrative support, better information systems, and more organizational structure than most networks currently have," the report says.

Interestingly, much of the appeal of specialty networks to physicians has been the limited financial commitment required, the report says. "Requiring a more substantial financial contribution will test the strength of specialists' commitment to these organizations." ■

About the Report

The report, *Case Study Analysis of Single Specialty Physician Networks* was sponsored by The American Medical Association, Chicago; The American Academy of Dermatology, Schaumburg, Ill.; The American Academy of Otolaryngology—Head and Neck Surgery, Alexandria, Va.; The American Academy of Pediatrics, Elk Grove Village, Ill.; The American College of Radiology, Reston, Va.; The American Society of Plastic and Reconstructive Surgeons, Arlington Heights, Ill.; The American Urological Association, Baltimore; The Michigan State Medical Society, East Lansing. To get a copy of the 89-page report, readers may call Patti Backaroy at the Michigan State Medical Society. The price is \$25 for members of the sponsoring organizations and \$95 for non-members.

Risk-based Contracting Opens Opportunities for Specialists



Kent J. Thiry is president and CEO of Vivra Inc., a company in San Mateo, Calif., that provides physician network and disease management services to managed care organizations. It works in partnership with physi-

cians in 15 specialty areas: asthma and allergy; cardiology; chiropractic; dermatology; ear, nose, and throat; gastroenterology; general surgery; hematology and oncology; neurosciences; obstetrics and gynecology; ophthalmology; orthopedics; physical therapy; podiatry; and urology. Vivra has 3,000 participating physicians and contracts to provide care for 7 million covered lives, mostly in the Eastern United States. In 1991, Thiry joined Vivra as president and chief operating officer. He was appointed CEO in 1992. Before joining Vivra, Thiry worked as a partner at Bain & Co., an international management consulting company in Boston, and as a senior consultant with Andersen Consulting. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. Could you describe how the Vivra network works?

A. Each Vivra network has one or more contracts with managed care organizations (MCOs) to provide physician services in an individual specialty in a specified geographic area. Physicians participate on a nonexclusive basis by contracting with the Vivra network, the health plans, or both. Physicians can still see fee-for-service patients and contract with other networks, IPAs, groups, and plans.

Each Vivra network is led by prominent local physicians and a physician advisory committee that consults on financial, clinical, quality, and utilization issues. Although they contract with PPOs and other payers, Vivra networks typically are dedicated to delivering care on a capitated basis.

Q. How are physicians who contract with Vivra paid?

A. In capitated networks, the capitation amount received for professional ser-

vices each month is apportioned to participating physicians based on patient services the physicians provide and the relative value assigned to each service by Vivra and the network's physician advisory committee. In some networks, any institutional savings that health plans would achieve as a result of improved member wellness and lower hospitalization rates also are shared with participating physicians. These funds are distributed based on performance measures, such as cost-effectiveness, member satisfaction, and clinical outcomes, which are determined by the advisory committee.

The physician governing committees have several other functions as well. Clinically, they collect the opinions of dozens of network physicians to identify the specialty's most significant issues. Next, they identify key indicators to be measured, and they use practice and outcomes data that are analyzed by Vivra Network Services, which is our information services department, to develop standardized practice protocols that can be applied across the network to improve clinical outcomes for an entire population, rather than just one patient at a time.

Using this system, the physicians and Vivra can reduce costs and improve quality. Since Vivra specializes in collecting and reporting large volumes of health care data, our physicians can identify and eliminate unnecessary variances in treatment that create clinical and cost inefficiencies.

Q. Are Vivra physicians employed?

A. Vivra has acquired some physician practices, but the vast majority of specialists in Vivra networks remain in independent, private practice, either as individuals or in small groups. Structured as IPAs, Vivra networks provide an expert, experienced infrastructure for managed care contracting, allowing physicians who are in private practice to provide the necessary geographic coverage, data tracking, and member survey capabilities most MCOs require. Since Vivra provides this infrastructure, participating physicians do not need to invest in overhead.

As a result, Vivra enables specialists to remain independent while also expanding their practices and protecting their market share.

Q. How are Vivra physicians selected and credentialed?

A. At the outset of health plan contracting, physician selection is essentially plan-driven to meet various geographic, volume, and subspecialty criteria. As the network matures, selection becomes more of a balance between the needs of contracting plans and the network's own performance goals.

Routinely, we check the status of a physician's liability insurance policy and his or her hospital privileges. Beyond that, the contracting HMOs usually are responsible for credentialing physicians in accordance with standards from the National Committee for Quality Assurance, an agency in Washington, D.C., that accredits health plans, and other quality-assurance organizations.

Q. In the past 12 to 18 months, MCOs have allowed consumers to gain greater access to specialists. Is this trend influencing your plans to build specialty networks?

A. Absolutely. In fact, that was one reason we began about two years ago to invest significantly in specialty networks. Our networks are designed to be flexible and to meet the needs of the contracting MCO. For example, we enable physicians to manage themselves so that they can assume the risk from a plan that wants to introduce open access but is worried about the economic consequences; alternatively, we allow the plan to retain the risk and work with the physicians in a way that makes sense to them.

Q. So, decisions on how the financial risk of delivering care gets apportioned are made on a market-by-market basis?

A. Right. The actual implementation of an open-access plan is particular to and differs dramatically from one market to the next, even within a market, depending on the orientation of the HMO.

Q. Do decisions on accepting financial risk depend on the specialty too?

A. No. As long as the network has the correct information and infrastructure,

any specialty can manage the financial risk of delivering care successfully. In that way, no specialty is inherently better off than any other specialty. Also, any specialty could have that risk retained by the payer.

Q. *Some specialists are more sophisticated about managed care than others. Cardiologists, for example, seem to be more sophisticated than gastroenterologists.*

A. Right. In our experience, those differences exist but they're largely proportional to the size of the per member per month (PMPM) fee that managed care plans pay. The larger the dollars involved, the more likely it is that either the plan or the physician group will begin to accept risk. If you are an ear, nose, and throat specialist, or a specialist with an even smaller PMPM, you might have approached a payer three years ago and said, 'I'd like to talk about assuming some of the financial risk of delivering care.' The payer likely would have said, 'Not right now. We're working on cardiology, and we'll get to you in a year or two.' Even if you had equivalent interests, it just wouldn't have played out.

There is one exception: Because of its importance in Medicare, gastroenterology is one of our strongest product lines in which we have a superior track record of reducing expenses and improving quality.

Q. *It seems that consumers believe specialists deliver better care than primary care physicians (PCPs) for many disorders. With asthma or congestive heart failure (CHF), for example, specialists have been shown to have better outcomes than other physicians. Is that factor driving the growth of specialty networks?*

A. Yes, that was one reason we founded Vivra. For many conditions, specialists are in a better position to generate superior clinical, economic, and customer service outcomes. The evidence supporting this result is growing now that a number of PCP gatekeeper plans have had a few years of actual experience and data.

Every year more studies come out that compare the clinical, economic, and patient satisfaction outcomes for a number of high-cost or complicated clinical cases. Those in which the PCP gatekeepers have been removed or in which the PCPs are more closely integrated with specialists are generating the superior outcomes.

Q. *Specialists are saying, 'We're so good at what we do that we can outperform anyone else who's handling these diseases, so you*

might as well let us do it.' Is that fair to say?

A. That's correct. If you're running a health plan, most of your costs are from patients who are under the care of specialists. Also, those patient segments have the most variation in cost, quality, and patient outcomes.

Conversely, if you're a PCP, on any given morning, you might have in your waiting room a severe diabetic at 9 a.m., a severe asthmatic at 9:45 a.m., a patient with emerg-

ing CHF at 10:15 a.m., and a patient with sinusitis at 11 a.m. It's impossible for you to pass up an offer from a procedural point of view or from the clinical point of view to have specialists deal with these clinical cases. Each of these patients has his or her own needs in terms of what the nurse should be able to do, the educational material that is needed, the kind of follow-up that is required. Also, some patients will require more focused clinical expertise at the point of diagnosis. The visit to the PCP often involves redundant diagnostic testing because that patient still needs to be sent to the specialist in order to prevent him or her from getting sicker and having a lot of high-cost complications later.

Q. *Yes, but by accepting the financial risk, aren't these physicians taking away some*

"If specialists can organize themselves ... the current trend toward more open access may be the best thing that's happened to specialists since the dawn of managed care."

ing CHF at 10:15 a.m., and a patient with sinusitis at 11 a.m. It's impossible for you to pass up an offer from a procedural point of view or from the clinical point of view to have specialists deal with these clinical cases. Each of these patients has his or her own needs in terms of what the nurse should be able to do, the educational material that is needed, the kind of follow-up that is required. Also, some patients will require more focused clinical expertise at the point of diagnosis. The visit to the PCP often involves redundant diagnostic testing because that patient still needs to be sent to the specialist in order to prevent him or her from getting sicker and having a lot of high-cost complications later.

What's happened is the PCPs say to members: 'I knew before you walked in that you had to see a cardiologist but before I can tell you to do that, there are certain steps I need to take.' There's nothing a member dislikes more than hearing he or she needs to go through two appointments, four phone calls, or a 10-day wait when any pragmatic clinician knew that the patient needed to see a specialist.

Q. *What you're saying is that specialists are so much better at handling specialty care that they're willing to accept a substantial amount of financial risk to do so. They're willing to put their money where their mouth is, so to speak. Is that right?*

A. That's correct. We've seen a dramatic shift in just the last 12 months around the country in terms of the percentage of spe-

cialists who are willing to put their money where their mouth is, and a lot of that is because there are companies out there, like ours, that take away much of the fear of the unknown because we've helped other physicians do that in other markets. Therefore, companies like ours are like an economic security blanket for those who enter into those arrangements.

A. Assuming a plan can successfully manage these costs by itself, it would be in its economic best interest to continue doing so. But that assumption is not true. If you're running a \$250 million plan and you can choose either to institute a system that will save \$1 million and achieve modest clinical quality improvement all by yourself or to work with some local specialists and get \$6 million in savings and dramatic clinical quality improvement, the choice is clear, even if you're going to get only half of the savings.

Furthermore, if one of your competitors begins to work with physicians in specialty networks, then everyone likely will follow that model because HMOs tend to be concerned about falling behind.

Q. *If you were running an HMO, why not just hire the appropriate number of specialty physicians? How do you get better cost savings and better customer service when you contract with specialists in a network?*

A. Many physicians have no interest in selling themselves to a payer because every physician works with multiple payers, and as soon as you sell yourself to one, you shut yourself off to quite a few others.

In addition, it's more effective for the plan to contract with specialists because then all the physicians in your network recognize that they've got to deliver every single year for the practice to continue to be the network of

(Continued on page 10)

(Continued from page 9)

choice. Conversely, once you've brought something in-house, you lose a lot of the natural incentive and flexibility that come with dealing with multiple outside factors.

Q. *Why has the trend of contracting with networks of specialists, which you said earlier has taken off in the last 12 months, become so strong right now?*

A. When we started doing this work two years ago, most HMOs and PPOs were comfortable having PCPs handle all cases and referring patients to specialists when

of hours of extra time to make it happen.

Q. *Can you provide an example of how a network of specialists will treat a particular disease, such as CHF?*

A. CHF is a good example. First, we identify patients who could use extra support by working with the physician practices in the plan. Then, we offer telephonic patient support at a minimum, and in some cases, actual home care or other forms of personal care. We have customized software to track progress of the patient with timely feedback.

We can reduce hospitalizations and emer-

gency room (ER) visits by teaching patients how to manage their conditions better. These patients are supported by home health nursing assessments and by interactive checkups over the telephone.

Q. *Some disease management specialty companies are offering guaranteed savings, guaranteed improvements in outcomes, and guaranteed improvements in patient satisfaction. Would you recommend this strategy to your specialty networks in order to win business from HMOs?*

A. We currently do that. When you are good at what you do, you can put that on the table with confidence and send a very strong message to all parties concerned. But some payers have gotten burned through these types of offers because they were working with a company that was inappropriately confident. As a result, they ended up with a mess on their hands when the arrangement blew up six months later. To offer guarantees opens eyes, but you should be cautious and sophisticated about what you're buying.

Q. *Do you offer all three guarantees? It's one thing to offer guaranteed savings, that's not hard. But to guarantee all three is difficult.*

A. We track patient satisfaction, and although our track record is strong there, we don't have any particular guarantees about it and I don't think it's controversial that we don't. On the cost front, we do guarantee savings. On the clinical improvement front, I don't think we've ever guaranteed anything, but, again, it's because our evi-

"As long as the network has the correct information and infrastructure, any specialty can manage the financial risk of delivering care successfully."

necessary. Since then, plans have tried to work directly with specialists but failed mostly, not because of a lack of dedication on their part but for more practical reasons. If I'm a cardiologist, I'm not going to go to the Aetna meeting on Monday night, the CIGNA meeting on Tuesday night, the Prudential meeting on Wednesday night, and the Blue Cross/Blue Shield meeting on Thursday night, and walk through the same issues each night about how to improve care for CHF patients.

Conversely, if a third-party arrives and says, 'We're going to create a network of cardiologists, would you work with us in governing that network? We're going to have one meeting a week to talk about how to care for patients appropriately and efficiently.' The doctors will be willing to join such a network and begin to take coherent action that cuts across several plans.

Q. *Something else happened with health plans. They started to squeeze costs, but could squeeze only so much, and they were not experts in managing specialty care costs. They were also alienating patients, who had to go through so many different procedures. After a while, the plans said, 'There must be a better way to do this. Let's let the specialists be specialists and see how that works.' Do you think that is what happened as well?*

A. Yes. The health plans couldn't work with specialists efficiently and couldn't generate the kind of results that are possible. If we have specialists who are motivated to control expenses, they will put in hundreds

of hours of extra time to make it happen.

gency room (ER) visits by teaching patients how to manage their conditions better. These patients are supported by home health nursing assessments and by interactive checkups over the telephone.

It's a fully integrated, multidisciplinary program, coordinating PCPs and specialists to empower CHF patients at highest risk. Patient satisfaction is very high, particularly with regard to self-confidence and their ability to self-manage a complicated and frightening disease.

When you take these straightforward steps, you can realize a 90% reduction in ER visits and a 25% to 30% reduction in hospital days within six months of starting the program. These results are stunning, and are literally a result of doing a few things that fell

"Differences among specialists are largely proportional to the size of the fee. The larger the dollars involved, the more likely it is that either the plan or the physician group will begin to accept the financial risk of delivering care."

through the cracks under the old delivery system. Under previous systems, we had a lot of sick patients who were nervous and scared, and their families were nervous and scared, and they used the ER for security and as a substitute for having no one to talk to. By establishing a personal relationship with

dence there is so strong. It is not a dubious assumption that our results will show a dramatic improvement in clinical outcomes.

Q. *What do you see as the future of specialty networks and medical group management companies? Do you think specialty management entities will be a growing force?*

A. The future of specialty physician networks is exceptionally bright because the pervasive trend among MCOs is to offer members better choice and better access, which you cannot do through a primary care contracting system. Once you have a broad and accessible specialist panel, however, you then need expert management across the broad specialties.

Consumers want choice and access and are voting with their dollars and their feet. In medicine today, specialists already manage most of the costs in the form of procedures and hospital admissions. Even more important, they are the ones who manage the patients and disease states with the most dramatic variances in outcomes, both clinical and economic.

If specialists can organize themselves and present to payers a coherent clinical and business proposition that includes high levels of service to plans and patients, the current trend toward more open access may be the best thing that's happened to specialists since the dawn of managed care.

Q. *What do you say to skeptics who argue that instead of providing one-stop shopping, PPMCs and specialty networks further fragment the system and mainly function as a mechanism for protecting physicians' income?*

A. We absolutely favor protecting and enhancing physicians' income, but we recognize there's a right way and a wrong way to go about that. The wrong way is to think you can do it by resisting any form of coordinated care, quality improvement, or rationalization of health care delivery.

The right way is just the opposite: to work proactively with payers to do all of those things. Working in partnership with payers, and in a professional network focused on the most important clinical and economic advantages that specialists can deliver, specialists can help their income go up, the payer's income can go up, and patients can be better served.

You have to be a partner to share fully in the benefits of managed care's cost and quality improvements. So, if you're talking about winning in the pay category over the long term, most people already realize that using specialty networks in some way to protect unmanaged, uncoordinated fee-for-service care is not the way to go.

Q. *I receive many calls from allergy and asthma specialists who complain about*

being left out of managed care; how do they fit into the system?

A. Some specialists are being left out. Others are at risk of being left out, particularly in some markets where some payers have falsely concluded that PCPs can take care of high-cost disease cases. We believe that coordinated specialty care is the most effective clinical and economical way to improve health care in the United States.

Q. *Everyone is guessing about the future of global capitation. Some believe it will put an end to the fee-for-service system permanently, while others think capitation doesn't work. Vivra has both types of contracts; what do you think is the wave of the future?*

A. The whole issue of global capitation is one where there's a lot of heat but little light. The fact is, the rate of growth in dollars capped globally in the commercial market over the last few years is almost flat despite

to be exceptionally slow because the Health Care Financing Administration is profoundly ambivalent on the subject. Therefore, from an economic point of view, they are largely irrelevant for the next several years to a company like ours that operates in multiple markets across the country.

Furthermore, to the extent that they do allow more direct contracting, we are one of the organizations in the best position to do that and to help a hospital system or multi-specialty group to do it. In partnerships with PSOs, we offer the geographic coverage, choice, and access that they otherwise wouldn't have.

People have been attempting to do direct contracting for a long time. It's complicated. It's also interesting to discuss, but largely irrelevant in its pure form because in the real world it usually evolves into some form of

"For many conditions, specialists are in a better position to generate superior clinical, economic, and customer service outcomes."

millions of dollars and millions of hours of executive time invested by provider groups and hospital systems to procure these contracts. Consumers' demand for access and choice and providers' ability to contract intelligently for pieces of risk, as opposed to globally, mean that in most markets, global capitation will remain a secondary way of doing business.

Q. *Is Vivra interested in contracting with integrated delivery systems and provider-sponsored organizations (PSOs)?*

A. First, integrated delivery systems rarely have been able to obtain risk or exclusive contracts. Second, even when they have been able to do so, their track record in terms of managing utilization and improving clinical outcomes is abysmal compared with the more focused specialty networks and physician organizations.

At the same time, it doesn't matter to us if the integrated system is the point of entry for the plan on a one-stop-shopping basis or if the plan contracts with multiple entities because we will often be the specialty subcontractor for the integrated delivery system.

As for PSOs, their emergence is going

partnership between the payer and the provider, with a more thoughtful division of responsibilities and an elimination of redundant administration. The partners work out the specifics—such as who can do precertification, the provider group or the payer? Who's going to go to the employer clinic and talk about diabetes: an HMO employee or a provider employee?—the partners work these issues out and responsibility shifts accordingly.

A wholesale shift of all the payer functions to the PSO is most unlikely because most employers want to work with a provider base that is so broad and varied that you need administrative integration at the point of service, and that's what HMOs do. HMOs have delivered this service for many years and likely will continue to work with providers to handle administrative functions. HMOs have administration skills and marketing experience, and physicians and hospitals are unlikely to want to reinvent the wheel. In 90% of the country, the whole PSO issue will be resolved as an incremental shifting of responsibilities between providers and plans. ■

A Look at the Legal Implications of Physician-Hospital Relationships

By Katherine A. Nino, JD

To retain and to increase market share, hospitals are purchasing physician practices and entering into other financial relationships with physicians in unprecedented numbers. Not only has this activity helped to drive up the value of some physician groups, it has also raised concerns about the legality of many physician-hospital transactions. Therefore, physicians considering any financial relationship with a hospital should be aware of the numerous laws involved and proceed with caution.

The critical laws implicated by physician-hospital relationships are the Medicare and Medicaid Anti-kickback Statute and the federal Physician Self-referral Law, both of which are part of the Social Security Act. In addition, where physicians enter relationships with tax-exempt hospitals, the federal tax laws, including the Intermediate Sanctions Law, play a role. Violations of those laws can result in substantial monetary—and, in some cases, criminal—penalties. To ensure that a financial arrangement with a hospital is structured legally, physicians should consult a qualified attorney.

The Anti-kickback Statute

Also known as the anti-fraud and abuse statute, the federal Medicare and Medicaid Anti-kickback Statute makes it illegal to receive remuneration in exchange for, or to offer or to pay remuneration in order to induce, the referral of Medicare or Medicaid beneficiaries. [42 U.S.C. 1320a-7b]. Remuneration includes anything received, offered, or paid “directly or indirectly, overtly or covertly, in cash or in kind.” Physicians who violate the statute can be excluded from the Medicare and Medicaid programs. Violation of the statute also can result in substantial criminal and civil penalties, including fines of as much as \$25,000 or imprisonment for as long as five years.

Katherine A. Nino, JD, is a staff attorney in the AMA's Health Law Department.

To prove a violation of the Anti-kickback Statute, a prosecutor must show that a defendant “knowingly and willfully” offered or paid remuneration to induce referrals. If even one purpose of an arrangement established for various legitimate purposes is to induce referrals, that arrangement would be

found to violate the statute. Although a 1995 Ninth Circuit Court of Appeals held in *The Hanlester Network v. Shalala* (51 F.3d 1390) that the prosecution must show that the defendant acted to induce referrals with the specific intent to disobey the law, this approach has not yet been adopted in other

Federal Regulations Offer 13 Safe Harbors to the Anti-kickback Statute

Federal regulations provide 13 safe harbors to the Anti-kickback Statute. The following illustrates two that apply to physician-hospital relationships

1. Personal Services and Management Contracts Safe Harbor. If a physician refers Medicare or Medicaid patients to a hospital and the hospital pays the physician to perform certain services—such as serving on a committee or as chief of a department—the payment will not be considered remuneration under the Anti-kickback Statute, and the relationship itself will not violate the Anti-kickback Statute, provided:

- There is a signed, written agreement specifying the services covered by the arrangement;
- If the agreement is for services provided on a periodic basis, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals;
- The term of agreement is for not less than one year; and
- The compensation is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of Medicare or Medicaid referrals between the parties.

2. Space and Equipment Rental Safe Harbor. If a physician rents office space or equipment from a hospital to which he or she also refers Medicare or Medicaid patients, the rental payments will not be considered remuneration under the Anti-kickback Statute, and the rental arrangement itself will not violate the Anti-kickback Statute, provided:

- The lease agreement is written and signed by the parties;
- The lease specifies the premises covered by the lease;
- If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals;
- The term of the lease is for not less than one year; and
- The aggregate rental charge is set in advance, is consistent with fair market value in arm's length transactions, and is not determined in a manner that takes into account the volume or value of any Medicare or Medicaid referrals between the parties. In this case, “fair market value” means the value of the rental property for general commercial purposes, without any adjustments for the additional value attributed to the property as a result of its proximity or convenience to sources of Medicare or Medicaid business or referrals.

Exceptions to the Stark Laws

Physician-hospital relationships that meet the requirements of an exception to the Stark laws do not violate the Stark laws. The following illustrates two exceptions to the Stark laws that apply to physician-hospital relationships:

1. Hospital ownership exception. If a physician has an ownership or investment interest in a hospital to which he or she also refers Medicare or Medicaid patients for designated services, referrals to that hospital will not be prohibited under the Stark laws, provided:

- The referring physician is authorized to perform services at the hospital; and
- The ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

2. Space rental exception. If a physician rents office space from a hospital to which he or she also refers Medicare or Medicaid patients for designated services, the rental payments will not be

considered compensation, and the rental arrangement itself will not violate the Stark laws, provided it meets each of the following requirements:

- The lease is written, signed by the parties, and specifies the premises covered by the lease;
- The space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee;
- The term of the lease is for one year or more;
- The rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and
- The lease would be commercially reasonable even if no referrals were made between the parties.

jurisdictions. Consequently, the mere intent to induce referrals is sufficient to prove a violation of the statute.

To avoid prosecution under the Anti-kickback Statute, physicians should ensure that they enter relationships that fall within either a specific exception to the Anti-kickback Statute or one of its 13 regulatory safe harbors (see sidebar: "Federal Regulations Offer 13 Safe Harbors to the Anti-kickback Statute"). By definition, financial arrangements that fall within a safe harbor do not violate the Anti-kickback Statute. However, arrangements that do not qualify under a safe harbor are not necessarily illegal. The legality of such arrangements must be determined through careful scrutiny of the statute itself.

Physician Self-referral

The federal Physician Self-referral law—commonly known as the Stark laws, after sponsor Representative Fortney "Pete" Stark (D-Calif.), prohibits a physician (or a member of a physician's immediate family) who has a "financial relationship" with an entity from referring to that entity any Medicare or Medicaid patient for a "designated health service." Medicare or Medicaid payment will be denied for services provided in violation of the Stark laws. Violation of the Stark laws can result in significant civil money penalties and exclusion from the Medicare and Medicaid programs.

The Stark laws also contain exceptions,

which, if satisfied, would allow physicians to make referrals to entities with which they have financial relationships. Unlike the Anti-kickback Statute, however, failure to comply with a statutory exception is sufficient to violate the Stark laws.

"Financial relationship" is defined as a compensation arrangement or as an investment or ownership interest. Consequently, a wide array of physician-hospital relationships potentially falls within the purview of the Stark laws. However, such relationships will be scrutinized only to the extent that the physicians involved refer Medicare or Medicaid patients to receive "designated health services," defined to include:

- Clinical laboratory services;
- Physical and occupational therapy;
- Radiology, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound;
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices;
- Home health services and supplies;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services. (See sidebar, "Exceptions to the Stark Laws.")

Intermediate Sanctions

In general, the federal tax laws prohibit tax-

exempt organizations from conferring excess benefits upon private shareholders or individuals. In the past, the sole penalty for physician-hospital transactions in violation of these laws was the loss of a hospital's tax-exempt status. Under the recently enacted Intermediate Sanctions Law, however, physicians, too, are subject to substantial excise penalties for their role in prohibited financial relationships with tax-exempt hospitals.

The Intermediate Sanctions Law prohibits "disqualified persons" from receiving excess benefits in a business relationship with a tax-exempt organization. A "disqualified person" is defined as someone in a position to exercise substantial influence over the affairs of the exempt organization (the hospital). Therefore, if the facts surrounding a physician-hospital relationship demonstrate that the physician is a disqualified person, that physician may be subject to penalty if the financial arrangement in question confers excess benefits upon him or her. Examples of physician-hospital arrangements that could run afoul of the Intermediate Sanctions Law include non-fair market value transactions and unreasonable compensation arrangements. ■

For more information on these regulations, readers are invited to see 42 U.S.C. 1320a-7b, 42 U.S.C. 1395nn, 26 U.S.C. 4958, 26 U.S.C. 501(c)(3), and 42 C.F.R. 1001.952.

Venture Capital Investment in Health Care Slows

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

Venture capital continues to flow into health care services, although at a reduced rate. During the quarter that ended on June 30, venture capital firms invested \$204.1 million in the sector, a 20% decline from the amount invested in the first quarter of 1997. The size of the average deal fell from \$4.3 million per deal in the first quarter of 1997 to \$3.8 million in the second quarter. Among the factors contributing to this decline are the following:

- An increase in investments in the medical devices industry;
- More pressure on health care partners in venture capital firms to invest more

money and to achieve greater returns, thus moving them away from the relatively crowded health care services sector;

- Historically high rates of investment in the sector, leading to a glut of capital and possible overpricing of deals;
- Volatility in the stock prices of health care services companies and questions about the public markets' continued support of physician practice management companies (PPMCs) as entities that consistently add significant value to the physician practices they acquire. Venture capitalists' favorite investments in the health care services sector have been

PPMCs and managed care organizations. The largest investment in the sector during the first half of 1997 went to Franklin Health, a managed care services company in Upper Saddle River, N. J. Willis Stein & Partners in Chicago provided \$27 million to Franklin Health so that management could buy back the company from Corning Inc., in Corning, N.Y. PPMCs also have attracted venture capital. Venture capital firms have been attracted by the ability of PPMCs to grow rapidly through acquisitions followed by initial public offerings. The accompanying table lists selected investments by venture capital firms in PPMCs. ■

Selected PPMC Investments by Venture Capital Groups (1996 and 1997)

Company	Location	Description	Amount raised (in millions)	Venture capital investors
Accountable Oncology Associates	Alexandria, Va.	Oncology PPMC	\$2.5	North Bridge Venture Capital, Waltham, Mass.; Johnson & Johnson Development Corp., New Brunswick, N.J.; CGJR Capital Management, Nashville
American Dental Partners	Wakefield, Mass.	Dental PPMC	\$30.0	Summit Partners, Palo Alto, Calif.
Cardiovascular Provider Resources	Dallas	Cardiology PPMC	\$7.0	Summit Partners, Palo Alto, Calif.
Health First Physicians	Denver	Primary care PPMC	\$35.0	TA Associates, Boston
MatureWell	Tucson, Ariz.	Geriatric care PPMC	\$2.0	Mayfield Funds, Menlo Park, Calif.
NovaMed EyeCare	Chicago	Ophthalmology PPMC	\$11.0	Sierra Ventures, Menlo Park, Calif.
Orange Coast Managed Care	Orange, Calif.	Primary care and occupational health PPMC	\$5.0	Sierra Ventures, Menlo Park, Calif.
OrthoLink	Nashville	Orthopedic care PPMC	\$30.0	Welsh, Carson, Anderson & Stowe, New York
Professional Dental Associates	Wellesley, Mass.	Dental PPMC	\$8.6	Dillon Read Venture Capital, New York; Commonwealth Capital, Wellesley, Mass.; Behrman Capital, New York; CW Group, New York
Value Oncology Sciences	Avon, Conn.	Oncology PPMC	\$10.0	Warburg Pincus, New York

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.

Report Says Managed Care Quality Varies Widely

The National Committee for Quality Assurance (NCQA), an HMO accrediting agency in Washington, D.C., says the quality of care delivered at HMOs and other managed care organizations varies greatly nationwide. Titled *The State of Managed Care Quality*, the report says managed care plans offer a wide variety of quality within regions and across regions in terms of preventive care, treatment of acutely ill and chronically ill patients, and member satisfaction.

Heart attack patients in the South Central region, for example, are treated with beta blockers less than 20% of the time in some health plans, but more than 90% of such patients get beta blocker treatment in the best-performing plans. Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas are in the South Central region.

If all managed care plans performed at the level achieved by the best plans, the health of Americans would improve significantly, NCQA said. If all plans screened their female members for breast cancer at the benchmark level, for example, 1,200 more cases would be detected each year, according to the report.

The report contains performance, accreditation, and patient satisfaction information from more than 300 managed care plans. It examines and compares performance across the managed care

industry, affording a view of national, regional, and state averages, and benchmarks on specific measures of care and service. The data have been collected from the Health Plan Employer Data and Information Set (HEDIS), among other sources.

The report focuses on eight specific HEDIS measures:

1. Advising smokers to quit,
2. Beta blocker treatment,
3. Breast cancer screening,
4. Cervical cancer screening,
5. Cesarean section rates,
6. Childhood immunizations,
7. Diabetic eye exams, and
8. Prenatal care in the first trimester.

Comment: *The report shows that fee-for-service care is not any better than that available in managed care plans. Regarding C-sections, for example, NCQA reported that the national average rate among HMOs is 20.6%, yet the best-performing health plans have an average of 10%, the worst-performing plans have an average of 40%, and fee-for-service plans have an average of 29.1%. The report is available on the World Wide Web at <http://www.ncqa.org>.*

Survey Reveals Market Pressure on Managed Care Plans

A survey of senior executives at HMOs and PPOs shows that a significant percentage of respondents are concerned about rising costs and increased competition. Also, the respondents said current internal management practices are ineffective in dealing with these issues. The survey was conducted for William Cook Direct, an advertising agency in Jacksonville, Fla. Among the 200 executives were chairmen, presidents, CEOs, senior vice presidents, and sales or marketing directors for managed care organizations, ranging in size from those with enrollments of 30,000 or fewer to those with more than 500,000 members.

Among respondents, 34% said controlling costs while delivering quality care was the most important challenge they faced. Some 23% of respondents cited competition with other managed care organizations as their biggest challenge, and 27% of respondents said they needed more effective strategies to compete effectively.

Comment: *The respondents said another pressing problem was sustaining enrollment levels. Forty percent of respondents said disenrollment of members in commercial plans had increased between 6% and 20% last year. At the same time, 73% of respondents had increased their enrollment growth goals for 1997 by at least 25%.*

Hospitals Struggle to Manage Physician Practices

In the race to purchase and manage physician practices successfully, hospitals are finishing in last place, according to a report by the Croes/Oliva Group, consultants in Burlington, Mass. Physician practice management companies (PPMCs) and medical groups have been successful in buying physician practices and in making a profit from these acquisitions, according to the report, *Physician Partnering: Gaining Value from Physician Practice Management Arrangements*. Hospitals, however, have failed to profit from the acquisition of medical practices, the report says. Other reports have said hospitals have lost \$100,000 per physician per year on acquired physician groups.

Commentary: *Hospitals have lost money on acquired physician practices for three reasons. First, they pay higher salaries than PPMCs or physician groups pay. Second, hospitals overestimate the opportunities to raise revenue and to reduce costs. As a result, they pay too much when acquiring physician practices. Third, hospitals tend to overestimate the opportunities for increased revenue from referrals from owned practices. Fourth, physician productivity declines when physicians go from working for themselves to being employed.*

Oxford's Specialty Program Exceeds Expectations

More than 700 physician specialists have joined specialty teams developed by Oxford Health Plans, an HMO in Norwalk, Conn. The specialists work in teams to coordinate all phases of care, including evaluations, lab tests, radiology, hospitalization and procedures, consultations, rehabilitation therapies, and home care. Under this model, specialists need not seek pre-approval for tests or procedures.

Until now, most HMOs have been billed for each visit and procedure required in the treatment of all conditions, plus additional amounts for diagnostic tests, hospital services, blood-laboratory reports, and follow-up care, such as physical therapy.

Oxford's teams of specialists are reimbursed when they achieve certain clinical quality milestones in each case. The payments are based on outcomes, providing an incentive to solve problems and foster healing, Oxford said. The health plan hopes the teams will lead to increased efficiency by reducing variations in treatment patterns, Oxford said. The model contrasts with fee-for-service and capitated arrangements in that it reimburses physicians for an entire treatment plan, from diagnosis through recovery.

"We designed this new model in response to our physicians' desire for more clinical autonomy and less intrusion by the health plan," said Oxford Chairman Stephen Wiggins. "Our goal is to buy solutions from physicians, not simply pay them for their time."

Oxford's approach reflects a nationwide trend to lift restraints that have enraged doctors, frustrated patients, and forced lawmakers to pass anti-managed care legislation in many states, according to *The New York Times*.

Comment: *Some physicians praised the team strategies, saying it shows that Oxford was listening to complaints from doctors and patients. Critics, however, said the new system could force physicians to bid for contracts and thus could adversely affect the quality of care, The New York Times said.*

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

December 1997



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

BULK RATE
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15