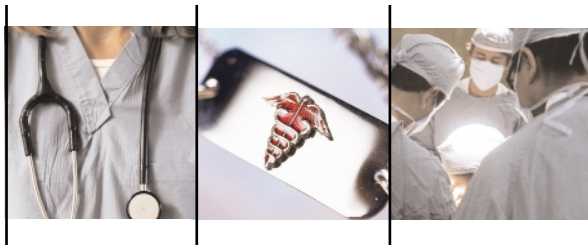
Issue Brief
Findings from HSC



HOW PHYSICIAN ORGANIZATIONS ARE RESPONDING TO MANAGED CARE

Despite a rash of troubles in 1998, physician organizations—formed in response to managed care plans—can thrive if they are locally owned, physician-run and rationally sized, said panelists at a recent roundtable organized by the Center for Studying Health System Change (HSC). The panelists also noted the market's slow progress toward global capitation as a way of compensating physician organizations, and the generally weak state of information systems required to support the goals behind capitation: accountability, efficiency and quality. This Issue Brief reports on governance, physician-hospital relationships, capital needs, compensation and other developments covered at the roundtable.

No One-Size-Fits-All Organizations

Physicians are key to the delivery of effective care, and their decisions drive approximately 80 percent of all medical spending. So any organization that wants to influence their behavior and control quality "needs to be able to come up with appropriate incentives and structures," said HSC health researcher Joy M. Grossman.

Consequently, a wide variety of physician entities have sprung up to organize physicians in ways that go beyond the traditional practice of medicine and billing. These organizations have attempted to consolidate physicians as a means to obtain more advantageous managed care contracts and gain administrative and clinical efficiencies. Such organizations have also sought to acquire capital to finance organizational growth; to develop information and clinical management systems to control costs and improve quality; and to develop strategies that tie physicians to larger, integrated health care organizations.

There is no one-size-fits-all physician organization. They may be locally owned and operated or regional/national in scope. They can be single-specialty or multispecialty practices. And they can be owned by the physicians themselves, a hospital, outside public or private investors or a health plan. Other defining characteristics are the management techniques an organization brings to bear, how active the physicians are in setting practice policy, the financial incentives physicians face and whether the organization is tied exclusively to one payer.

Many of the challenges confronted by physician organizations today stem from a sense that certain, hoped-for economies of scale have not yet emerged. For example, large practices tend to generate expensive new administrative complexities, including a layer of costly staff to support the organization. Moreover, larger entities, especially those formed from practices acquired by hospitals and physician practice management corporations (PPMCs), have often degraded physician performance, productivity and enthusiasm by shifting the doctors to salary-based compensation systems and eliminating or reducing their equity in the organization. How organizations attempt to balance their objectives of cost-effectiveness with physician satisfaction will be an important factor as health systems evolve in coming years.

CENTER *for* STUDYING HEALTH SYSTEM CHANGE

NUMBER 20 • MAY 1999

This Issue Brief is based on a roundtable sponsored by HSC, held January 27, 1999, in Washington, D.C.

Panelists

David Blumenthal, M.D., M.P.P.
Director, Institute for Health Policy, MGH/Partners Health Care System, Inc.

Joy M. Grossman, Ph.D.
Health Researcher, Health System Change

J.D. Kleinke, M.S.B.
Chairman, Health Strategic Network, Inc.

Jacob G. Kuriyan, Ph.D.
CEO and President, Physmark

Moderator

Paul B. Ginsburg, Ph.D.
President, Health System Change

Governance and Physician Involvement

One of the core attributes of a viable physician organization identified by the panelists was physician buy-in based on a strong role in governance. The panelists concurred that an organization cannot be imposed from the outside on physicians, who by nature are highly independent, strong-willed people with "an almost religious sense" of autonomy. Moreover, their accountability and liability for their patients' well-being is a powerful disincentive to share responsibility for medical management with others.

These complex sociological, legal and economic factors have produced governance models that are often unstable. Many small practices wind up running like dictatorships, noted Jacob G. Kuriyan, CEO of Physmark. "As long as it is a benign dictatorship, these things seem to work," he said, but often those models leave the leader/owner vulnerable to buy-out offers from PPMCs or hospitals. Larger organizations, said David Blumenthal, director of the Institute for Health Policy, MGH/Partners Health Care System, Inc., can maintain the trust of members by operating like a republic or representative democracy, "with legitimacy deriving from the fact that people are elected and accountable."

Countering this, Grossman cited an Orange County, Calif., independent practitioner association (IPA) that had seen its democratic model evolve into a more authoritarian approach as the IPA gained leverage in the market, and various groups within the IPA became hesitant to share data with the whole organization.

J. D. Kleinke, chairman of Health Strategic Network, Inc., differentiated between the natural leadership exhibited in good physician-run organizations and the technocratic approach of institutional practice mangers. Management by formula, he said, "is anathema to the practice of medicine." The bottom line, said Blumenthal, is that "legitimate physician organizations for the most part are run by physicians."

Physician-Hospital Relationships

Questions of leadership and practice management can be particularly prickly when hospitals acquire physician practices in an attempt to control a primary care network. Many of these relationships had been costly for hospitals, Kleinke noted, largely because of the rush by competing hospitals and PPMCs to acquire practices. As a result, prices were driven up to unreasonable levels. Moreover, hospitals and other entities that purchase practices often put doctors on salary without performance-based adjustments and end up paying excessive salaries with declining productivity.

This does not mean that hospitals cannot make excellent organizing partners. "If practices need capital, information systems and the ability to assume global risk, and want to appeal directly to consumers to neutralize health maintenance organizations [HMOs], then the local hospital is the place that makes the most sense to organize physicians," Kleinke says.

Kuriyan agreed that the hospital model can work, but said that the degree of hospital control and the willingness of doctors to live with that control depends entirely on the local marketplace. Moreover, he said, "it is a mistake to think that owning a person is the best way to have a good tie with that person. There are better ways of building a relationship." One of those ways is for the hospital to educate its physicians about the business of managed care. "If physicians understand why the world has changed and why, for example, global packaged pricing needs to occur, then hospitals will have done an invaluable service," Kleinke said.

Hospitals' natural advantage as organizers of physicians, according to Blumenthal, is not that they have particular skill ("they are terrible at it, for the most part"), but that they are immovable fixtures in the community, and their profitability makes them a good source of capital. Even though long-standing antagonisms often fester between hospitals and physicians, the doctors ought to take a second look. "Hospitals' localness is a major advantage," he said.

Raising and Spending Capital

The amount of capital a physician practice needs to use to grow and modernize depends on its ambitions, according to the panelists. Modest-size local organizations are sustainable without much financing, and the capital can usually be raised from the member/owner

doctors themselves, said Kuriyan. Grossman noted that traditional, local sources of capital, such as banks, are proving to be good sources of capital for smaller operations. If an organization wants to adopt all or some of the attributes of a health plan, however, financial requirements for solvency and information systems quickly run into the many millions of dollars.

The most conspicuous and complicated influx of capital to the physician sector in recent years, panelists agreed, has come from Wall Street. Investors saw vast potential for consolidation, standardization and economies of scale. But Kuriyan cited two flaws in that vision. First, investors were looking for returns similar to those being realized in other hot sectors, such as Internet stocks—an impossibility given that physician practices make modest margins in the best of times. Second, Wall Street-style investments require a clear exit strategy—a point at which investors can take their gains and leave the field. This is "very difficult when you are talking about a lifelong relationship between a doctor and a patient," he said. In addition, Blumenthal maintains that investors in the corporate PPMC model did not understand the product. Investors assumed the work of physician offices could be standardized and franchised, but the complexity of clinical decision making and physicians' natural distrust of outside managers have made that difficult.

Compensation and Capitation

It is widely assumed that the efficiency and practice style of physicians is intimately related to how their services are compensated. The incentives apply at both the level at which a health plan pays a physician organization or intermediary (e.g., capitation) and the way the organization pays the individual doctor (e.g., through bonuses for productivity). Kuriyan said that capitation clearly reduces utilization, but Blumenthal noted that evidence of capitation's effects on long-term quality of care is still not available.

While it has proliferated more slowly than many experts predicted, capitation has had

THREE PHYSICIAN ORGANIZATIONS: A STUDY OF CONTRASTS

To demonstrate how dramatically different physician groups can be, HSC prepared case studies drawn from experiences in three of its 12 Community Tracking Study sites. Most of the forces affecting physician practices nationwide appear in at least one of these cases. Each panelist introduced one case study; detailed descriptions of each can be found at www.hschange.com.

Community Hospitals Indianapolis (CHI), a four-hospital health system with ownership interest in the practices of more than 270 primary care physicians in about 120 offices, is a good example of an integrated system trying to get doctors and hospitals to work together with aligned incentives, said Kuriyan. While CHI may have made a miscalculation typical of hospitals in recent years in "acquiring physician practices without quite understanding why," it has brought both flexibility and uniformity to its affiliated physician practices. Doctors may affiliate with CHI in three ways: (1) as CHI employees in CHI-owned practices; (2) as members of groups in which CHI has a minority ownership interest; or (3) as private practice physicians with privileges at one or more CHI hospitals. Whatever their affiliation, nearly all CHI doctors are part of a physician-hospital organization that acts as a contracting entity and either a primary care or specialty IPA affiliated with the hospital that organizes medical management. CHI is re-evaluating its relationships with "owned" physicians, including introducing productivity-based compensation because it is losing money with this arrangement.

Harvard Vanguard Medical Associates is a not-for-profit, semi-exclusive group practice affiliated with Harvard Pilgrim Health Plan (HPHP)—the sole source of its managed care business—with 600 physicians and 300,000 covered lives. Blumenthal said that when the staff-model clinic was spun off from its former parent HMO in 1997, it was to test the theory that "physicians who govern themselves and have autonomy in their organization can do better at controlling costs and improving quality than they could in a more complicated organization in which they had less governance control." Vanguard instituted risk-sharing between HPHP and the physicians for the first time and developed a compensation system based in part on patient satisfaction. The organization has close ties to Harvard Medical School and an active research program that maintains a reputation for clinical innovation and excellence, another important factor in maintaining physician loyalty.

Thomas-Davis Medical Centers, of Tucson and Phoenix, is a striking example of the possible perils of corporate ownership, said Kleinke. In his "autopsy" of the 70-year-old group practice, he noted several mistakes in the final years of the practice. First, when the clinic and its owned HMO partner were sold to a large national HMO in 1994, some senior doctors/owners earned more than $3 million each, but in their role as employees of the new organization, they lost governing authority. Second, the HMO sold the physician practice to a national PPMC, keeping the health plan in what Kleinke characterized as an "arbitrage play" for a "bargain-basement" price on 380,000 covered lives. The PPMC that bought Thomas-Davis imposed stiff cost-cutting measures, inflaming the clinic's Tucson doctors to the point where they joined a physicians' union. The PPMC also suffered from the ultimately futile attempt to manage physicians from a corporate headquarters in a remote city.

"Physicians do not want to be in organizations. It is something they are forced into for survival."

—David Blumenthal

"It is a mistake to think that owning a person is the best way to have a good tie with that person. There are better ways of building a relationship."

—Jacob Kuriyan

"If practices need capital, information systems and the ability to assume global risk, and want to appeal to consumers, then the local hospital is the place that makes the most sense to organize physicians."

— J.D. Kleinke

ISSUE BRIEFS are published by Health System Change

President: Paul B. Ginsburg
Director of Public Affairs: Ann C. Greiner
Editor: The Stein Group
Author of this Issue Brief: Craig Havighurst

For additional copies or to be added to the mailing list, contact HSC at:
600 Maryland Avenue SW
Suite 550
Washington, DC 20024-2512
Tel: (202) 554-7549
Fax: (202) 484-9258
www.hschange.com

Update your address for the mailing list at **www.hschange.com/Guestbk.html**

positive effects on some physician cultures. Blumenthal said that the group he works with confronted the constraints of capitation by subdividing into "pods" of eight to 12 doctors who meet weekly to review complications or deaths and discuss difficult or expensive cases. "This level of organization requires capital and support in the form of assistance—statistical, technical and other kinds—to realize its full potential," he said.

While capitation has not been without problems ("it has forced physicians to think like adverse selection-avoiding insurance executives"), Kleinke noted that it also offers incentives for efficiency and quality that are too powerful to ignore. "Being more attuned to the process of care when there is some financial pain associated with sloppiness ultimately drives the market toward capitation or some variant of it," he said.

The ways in which individual doctors get compensated are, if anything, even less advanced than capitation systems. The panelists did note, however, that two of the case study sites had taken opposite approaches. Harvard Vanguard, upon separating from its HMO partner, adopted an individual compensation system based in part on the productivity of each physician and on the satisfaction of his or her patients. After being acquired by an HMO, Thomas-Davis doctors were shifted to a straight salary system, only to see productivity and physician motivation fall sharply.

Information Systems

Much of the ability of physician organizations to monitor their own costs under capitation, work with hospital partners and refine the efficiency and effectiveness of their own care depends on advanced clinical and financial information systems. The health care sector has talked about leveraging informatics for years, but providers on the front lines have not invested in the best the market has to offer, Kleinke said. This is because "we are dealing with generations of disincentives to measure and understand" the process of medicine.

Information systems make their own argument for smaller, local physician organizations. The per-doctor cost of an off-the-shelf system that serves a small group is significantly lower than the cost for a larger group that needs customization. "One of the biggest PPMCs in the country had 43 databases that were all not talking to each other," Kuriyan noted. The result is that many groups do not know their costs in real time, who their underperforming doctors are or how to identify their especially costly patients.

Future Directions

The panelists pointed to a future in which global capitation—a payment that covers all or most medical expenses—would proliferate, but not without more struggle. Kuriyan said that direct contracting between employers demanding value for their health care premium dollar and physician groups seeking to box out the insurer middle man would be part of this future landscape. Kleinke said that IPAs appear to represent the "most flexible, nimble and fungible" kinds of organizations. Physicians also may find them more participatory than corporate organizations.

Blumenthal attempted to sum up the attributes of a successful physician organization. It would require: (1) true cost accountability of each group; (2) abundant sources of data about utilization and quality; (3) physician leadership; (4) modest size, involving accountability among cells of around 20 to 30 physicians; and (5) a multispecialty orientation to facilitate efficiency and exchange of information across the care continuum.

The fundamental problem, said Blumenthal, is that "physicians do not want to be in organizations. It is something they are forced into for survival. The only compelling glue that holds physician organizations together is the opportunity to negotiate better prices," he said. "We haven't yet developed other services to the point where physicians truly see the added value sufficiently so that they are willing to pay for these services by giving up something." ●