Beyond HMOs: Understanding the Next Wave of Change in Health-Care Organization

Scott Gottlieb, BA, and Thomas A. Einhorn, MD

Abstract

The growing strength of managed care has diminished the financial and clinical autonomy of many orthopaedic surgeons. In part to offset these negative trends, new relationships are being developed to define doctors' methods of contracting with health-maintenance organizations. These include physician practice management companies (PPMs), independent practice associations, management service organizations, and physician-sponsored organizations. Each entity offers distinct advantages and disadvantages. While the PPM is the most popular new vehicle to offset adverse market trends, it carries with it some of the greatest potential pitfalls. In every case, before negotiating to join one of these new entities, it is important for a physician to have a solid understanding of the competing claims made by each entity, as well as insight into the fiscal health of the particular company in question. For some doctors, these arrangements offer a solution to current woes. For others, PPMs interpose another meddlesome intermediary in a market already bloated by layers of bureaucracy.

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Managed care has existed for almost three decades, and most of the current debate surrounding health-care reform has centered on the application of that concept. For many individuals, the term "managed care" has become synonymous with health maintenance organizations (HMOs). One in five persons with health insurance coverage is presently enrolled in an HMO, and at current growth rates, nearly one in three persons will be enrolled in an HMO by the year 2000.

One result of the increasing presence of managed care is that many physicians in solo and small, single-specialty group practices have watched their fee-for-service practices decline. For many doctors, HMO patients now constitute a greater portion of their practice base than ever before, and for many physicians, HMO contracts provide the greatest portion of their income. In part to protect their patient base and to preserve their clinical autonomy in the wake of these trends, many physicians have formed strong alliances with large physician groups, clinics, and hospitals. Others have sold their practices. One of every four physicians nationally reports that he or she is an employee of some such entity; this increases to one of every two for those under the age of 36.[1]

In response to these pressures, the economics and structure of medicine are undergoing fundamental and irreversible change. Competitive forces are driving the health-care industry to adopt new models of physician-patient and physician-HMO relationships. These changing relationships are likely to redefine the balance of control in the health-care marketplace in the same dramatic way that the introduction of HMOs reshaped health-care delivery more than a decade ago.

Developments in the marketplace are creating new opportunities for physicians to reclaim some of the economic power and the clinical freedom that many believe have been lost to managed-care companies. However, in those models in which physicians are regaining control of patient-care decisions, they may do so at the expense of having to change the ways in which they organize and function. The emerging entities with which doctors are affiliating constitute a veritable alphabet soup of medical-service companies

Mr. Gottlieb is a medical student at Mount Sinai School of Medicine, New York City. Dr. Einhorn is Professor and Chairman, Department of Orthopaedic Surgery, Boston University School of Medicine, Boston.

Reprint requests: Dr. Einhorn, Doctors Office Building, 8th Floor, Boston Medical Center, 720 Harrison Avenue, Boston, MA 02118-2393.

(Table 1). These include physician practice management companies (PPMs), individual practice associations (IPAs), management service organizations (MSOs), and physician-sponsored organizations (PSOs). In each scenario, individual physicians are organizing into larger groups. Those groups either compete directly with HMOs or use their collective size to negotiate more favorable terms with traditional managed-care companies. These alliances can unite hundreds of physicians into group practices within a delivery system that is integrated financially, legally, clinically, and operationally. As a result, these alliances can manage health-care costs across the continuum of care, thereby improving the physician's ability to remain competitive and to attract and retain managed-care contracts.

Table 1
Commonly Used Abbreviations in the Current Health-Care Environment

Abbreviation	Expanded Form	Description
HMO	Health maintenance organization	Accepts responsibility and financial risk for providing specified medical services at a fixed price
IPA	Independent practice association	Network formed for coordinated contracting with HMOs
MSO	Management service organization	Provides management services without owning the practice
PHO	Physician-hospital organization	Looser network for sole purpose of negotiating volume contracts
PPM	Physician practice management company	Third party buys a practice and manages business affairs
PSO	Physician-sponsored organization	Physicians own HMO

Orthopaedic surgery is one of a number of specialties that may be uniquely positioned to capitalize on these changes. Until recently, managed-care organizations treated referrals to all specialists in a similar fashion. Under this old arrangement, an enrollee's primary-care physician served as the gatekeeper who made all referrals to specialists, including orthopaedic surgeons, if the member was to qualify for reimbursement from the managed-care company. Recently, some of the larger managed-care companies have begun to rethink this model. For example, Oxford Healthcare in New York has developed a "case-rate system," whereby members of the HMO no longer need a referral to seek care from several types of specialists, including orthopaedic surgeons, cardiologists, and obstetrician-gynecologists. *The Wall Street Journal* reports that other managed-care companies are poised to follow Oxford's lead.[2,3] In situations in which HMOs no longer require primary-care physicians to control referrals to some specialists, organizations such as PPMs and MSOs built around single specialties are uniquely positioned to form partnerships with managed-care plans. Moreover, Wall Street analysts have predicted that since orthopaedic surgeons have wished to remain in single-specialty practices rather than join multispecialty groups, they may need the services offered by some of these newer alliances in order to compete with other large provider groups.[4]

Each of these entities is not without its critics, principally those who believe that these groups lack depth and are not always aligned with the best interests of physicians and their patients.[5] However, these new organizations hold out the promise that a new equilibrium will be found in the health-care marketplace whereby physicians can regain some of the economic hegemony and clinical autonomy that many in the profession believe have been lost to managed-care companies. This article will review the types of alliances being formed in today's health-care market, investigate the implications these changes may have on orthopaedic practice, and discuss how each model fits into new patterns of medical practice.

Physician Practice Management Companies

In mature health-care markets that are fully penetrated by managed care (i.e., managed care accounts for more than 30% of all reimbursements), the presence of HMOs compels doctors to seek out business partners. Wall Street analysts believe that when capitation reaches 30% of the geographic market, a

specialist can no longer remain independent.[6] (Capitation is a managed health-care reimbursement arrangement whereby the physician is prepaid a set dollar amount, on a per member–per month basis, for the delivery of health-care services to a defined group of members. The per member–per month reimbursement is a fixed amount regardless of the number of services a member uses.) Beyond this 30% threshold, physicians are required to aggressively track their costs. This task is often prohibitively difficult for small to mid-size orthopaedic groups, which frequently lack both the tracking system and the administrative manpower to assemble the necessary data. By forming alliances, physicians can efficiently pool resources and offset some of the costs associated with operating in markets dominated by cost-conscious managed-care companies. A small number of medical groups are achieving economies of scale by acquiring practices on their own and forming what analysts refer to as "roll-ups." However, most freestanding physician groups lack the capital, access to liquid funds, and financial expertise to make the transition to this type of arrangement. As a result, an increasing number of doctors have turned to PPMs. These companies bring together large groups of doctors and act as intermediaries between the physicians and the managed-care plans. The PPMs provide physicians with services that are designed to make their medical offices more efficient.

By enrolling large groups of doctors, the PPMs are able to sell complete medical-service packages to HMOs at a fixed fee. The PPMs can also improve on the manner in which doctors market their services and help negotiate volume contracts for their physician-members with other health-care providers, such as hospitals and vendors. The PPM brings in its own information system and does all of the doctors' billing, scheduling, staffing, and paperwork. The PPM may also provide capital to expand and give individual practices managed-care expertise and economies of scale.

Although the structure of the PPM varies between companies, under a typical arrangement, the PPM buys the hard assets of a physician-owned practice. In exchange, the doctors are given stock in the PPM company. The doctors remain employees of their own separate professional corporation, which agrees to sign a long-term service contract with the PPM (usually for 30 to 40 years). Typically, the doctors either are restricted from selling their stock in the PPM within a specified period of time or are allowed to sell only a small amount of the stock each year. Moreover, the doctors face onerous penalties if they decide to break their service contract and leave the PPM earlier than intended (under typical contracts, the doctors are forced to forfeit a substantial amount of the stock they received in the PPM and can even be subject to litigation).

In exchange for a fixed percentage of the annual net income of the practice, the PPM invests in the practice and manages its business affairs (in a minority of arrangements, the practice pays a fixed management fee to the PPM rather than a percentage of income). The medical office remains a separate entity that is affiliated with the PPM. The doctors collaborate on running the medical office through a governing board, on which they and their PPM partner have an equal number of seats. The board sets budgets, approves contracts, and ratifies all major business decisions (including the decision to purchase new equipment and take on additional business). Doctors retain sovereignty over all medical policy and physician-personnel matters. For example, the PPMs typically leave physician-compensation guidelines up to the doctors to decide. The PPMs also defer to physician-members on matters of physician recruitment and hiring.[7]

The theory behind the PPM is a belief that the company can manage the office less expensively and more efficiently than the doctors can, thus reducing costs. One aspect of this arrangement that appeals to many physicians is that the PPM takes over the business side of the practice, freeing doctors to focus on clinical issues. In this regard, the PPMs contend that their interests are in line with those of physicians.

Another important feature of the PPM is that it can provide capital to doctors to expand their practices. Doctors have traditionally relied on bank loans to finance capital improvements. However, banks have recently come to view medical practices as less desirable borrowers. Particularly in markets where managed care is cutting sharply into the earnings of local physicians, bank financing for the purpose of expanding a medical practice has become more difficult for physicians to secure. This makes the PPM's ability to raise large amounts of money through stock offerings attractive. The exchange of paper stock certificates for cash strengthens a PPM's balance sheet, thus allowing it to access very large short- and long-term lines of credit from major lending institutions. The cash and debt capital sources can be used to acquire more medical practices in new markets.[8]

Although this entity barely existed 6 years ago, PPM companies have proliferated. More than

30 practice management companies are listed on the NASDAQ and New York Stock Exchange public markets, and dozens more are waiting to go public. To date, about 8% of the nation's 527,000 practicing physicians have affiliated with PPMs. There are currently more than 40 public companies dedicated to physician practice management, with a total market capitalization of approximately $25 billion. In contrast, as recently as 1992, there were only four such public companies, with a combined market capitalization of $500 million. Some Wall Street analysts predict that the PPM industry could capture one third to one half of the physician-services market within 5 years.[9] In 1996, publicly traded PPMs generated revenues of about $14 billion. Analysts point to the total annual billings by US doctors (about $210 billion) and contend that there is considerable room for additional growth of these companies.[10]

A PPM usually follows one of three different strategies: (1) Some buy up small practices of 5 to 10 doctors, all located in the same region, and then consolidate them until the PPM has a network of up to several hundred physicians in one market. (2) Other PPMs buy large, centrally located multispecialty practices that employ 100 or more doctors and then acquire a number of smaller practices in the surrounding geographic area. (3) The most recent entries into this industry are PPMs that develop large practices based on a single specialty. The most likely specialties to be penetrated by practice management are the so-called high-cost areas of medicine, such as cardiovascular medicine (which accounts for 17% of total national health-care expenditures) and orthopaedics and oncology (which represent 5% each). Other specialty PPMs have been organized in obstetrics-gynecology and ophthalmology.[10]

The American Academy of Orthopaedic Surgeons estimates that, to date, about 10% of all orthopaedic practices have been approached by PPMs and that fewer than half of these (3% to 5%) have actually negotiated a buyout arrangement.[11] In view of the trend in other medical specialties, growth in the number of orthopaedic practices owned and operated by PPMs seems likely to accelerate.

One of the largest PPMs dedicated to orthopaedic surgery is OrthoLink, based in Nashville, Tennessee. It was formed several years ago with the combination of two of the largest orthopaedic physician groups in Nashville. Since its inception, the company has grown steadily and currently has approximately 155 practicing physicians in four states (Georgia, Colorado, Tennessee, and New Mexico), with plans to move aggressively into additional markets. OrthoLink has $120 million in aggregate annual revenues and operates 17 clinics with offices in 50 locations. Fueling the company's growth is a $30 million capital infusion from Welsh, Carson, Anderson & Stowe, a venture capital firm based in New York that has established its reputation in the financial community through its association with many successful PPMs.

The chairman of OrthoLink, Dr. David Alexander, Jr., who is also a practicing orthopaedic surgeon, predicts that the market for orthopaedic-based PPMs will expand in the future as managed-care companies move away from the gatekeeper concept for selected specialties. He also has said that the need for more sophisticated data collection and cost management on the part of physicians will continue to drive doctors toward the types of arrangements being offered by PPMs.

Another PPM dedicated to the orthopaedic marketplace is Specialty Care Network, which recently raised $21 million through an initial public offering of stock on the NASDAQ exchange and thus became the first publicly traded PPM to focus exclusively on the orthopaedic marketplace. Approximately 140 orthopaedic surgeons are currently affiliated with Specialty Care Network, representing 19 practices in nine states. In addition to practice management operations, Specialty Care Network also manages two outpatient surgery centers, one outpatient magnetic resonance imaging center, four physical therapy centers, and one occupational medicine unit. The trend established by Specialty Care Network may be followed by others, such as OrthoLink, which is also moving beyond managing orthopaedic practices into related areas, such as magnetic resonance imaging facilities and ambulatory surgery centers.

The past year has seen rapid growth in the orthopaedic PPM sector. While OrthoLink remains the best established of the orthopaedic PPMs, other practice management companies dedicated to orthopaedics either have sprung up this past year or have gained notable market share. These include Bone, Muscle and Joint, based in Florida, which was founded in 1996 and is backed by funding from two prominent Wall Street venture capital firms; Integrated Orthopedics, Inc; Omna, also based in Florida; and Ortho Excel, based in Columbus, Ohio.[12]

Current trends in the marketplace give PPMs an edge over many of the other existing health-care delivery models. The combination of declining utilization and an excess of doctors in many markets is leading to declines in revenues per patient and in physician

incomes. Health maintenance organizations are demanding and obtaining discounts from posted medical charges by threatening to exclude physicians from contracts. In addition, HMOs are reducing revenues per patient with the use of capitated payment arrangements, which now cover 33% of primary-care physicians. These arrangements on average account for almost 25% of the revenues of physicians contracting with HMOs. Health-care analysts are predicting that an increasing number of physicians will consolidate into PPMs in order to offset or counter these adverse market trends.[13]

Physician practice management companies have been successful for several principal reasons. First, they permit the sharing of administrative costs and office technologies. By spreading these services over larger patient volumes, the PPMs are widely credited with reducing overhead costs. Second, these companies also provide specialized staffs for evaluating and negotiating HMO contracts, analyzing actuarial and financial risks, and monitoring expenses and utilization relative to specific contracts. Lack of expertise in HMO contracting is a critical factor for many physician groups. Individuals who have had little experience in negotiating contracts have difficulty matching the experience of insurance companies and HMOs that negotiate hundreds of contracts each year. Third, funding requirements for more sophisticated information systems with which to monitor costs and utilization strain solo practices. Moreover, continuing consolidation in the health-care industry will support a need for growth through mergers and acquisitions. Such trends will increase working capital and financing needs and, in turn, require larger corporate structures with access to public debt and equity.[13] For these purposes, PPMs are ideally suited.

The PPMs will face increasing obstacles even as they continue to gain more market share. When PPMs move effectively into an area, they can transform the local markets, sometimes weakening the financial position of local hospitals. Hospitals worry that PPMs will exclude them from HMO negotiations, leaving the hospitals as merely vendors. In addition to those issues, PPMs hire physicians who might otherwise become hospital employees or contract with a hospital-run MSO.[14] As a result, some hospitals are entering into joint ventures with PPMs. In doing so, the hospital can ensure a steady stream of referrals from the PPM as well as a portion of the capitation dollar. For example, Loma Linda University Medical Center recently paid $30 million to buy a minority stake in PrimeCare, the largest PPM company in California's Inland Empire, a sprawling suburban area that includes all of Loma Linda's geographic market. The transaction will allow both parties to strengthen their existing business arrangements, which includes referrals of PrimeCare patients to Loma Linda Medical Center.[15]

While hospitals have viewed the spread of PPMs with ambivalence, unaffiliated independent physicians have on occasion been openly negative. The drawback cited most often is that PPMs require physicians to essentially sell their practices to the management organization and, in effect, become employees of the PPM. Most PPMs contend that their primary interest is in supporting their physician-members, but critics cite different motivations. When governing boards have a tie vote, typically the PPM has the final say on budgetary issues, and the doctors retain the deciding voice on clinical decisions. Problems arise when there is an overlap between those two interests, as, for example, when questions arise as to whether the practice will purchase new medical equipment.

Historically, the PPMs have often made it very difficult for doctors to leave the organization, for whatever reason, and set up practice elsewhere. The companies frequently require doctors to give back stock they received as compensation for selling their practice to the company in the first place. Additionally, many PPMs employ onerous non-compete clauses or so-called restrictive covenants, which preclude doctors from setting up a new practice in a geographic region in or adjacent to the PPM. These contracts sometimes include gag clauses, which are arrangements that restrict doctors from lodging public criticisms against the PPM.

There is also a question of how far the PPMs will go to clamp down on rising costs. To justify their very existence, PPMs must continually find ways to make physicians more productive and cost-effective. Practice management is new to orthopaedic surgery; however, in other fields, such as primary care, oncology, and occupational medicine, PPMs have had a longer track record. From the PPMs in these specialties, there is emerging a body of anecdotal evidence that suggests that when business sours, PPMs have tightened the financial reins over medical practice in ways that the physicians have found objectionable. At times these PPMs have even employed some of the same loathsome tightfisted measures physicians have attributed only to HMOs.[6] Wall Street health-care consultants typically advise physicians to avoid contracts that give them less than 50% control, particularly on issues of health-care delivery.[6]

Another area of concern is the public's perception of physicians who are associated with a publicly traded company. Most of the PPMs are for-profit corporations and issue stock that is traded on the public equity markets. Some physicians are concerned that in the long run, their interests and those of their patients could be subjugated to investors' desires to increase business profits. (Financially driven investors generally seek a 15% to 35% rate of return per year, which can unduly pressure doctors to generate growth.[16]) In addition, since the doctors selling their practices usually own a sizable portion of the PPM in the form of stock and options to buy stock, there exists the potential for the appearance of a conflict of interest between the doctors' desires to maximize gains on their shares in the PPM and at the same time to provide costly but necessary care to their patients. This is the same complaint doctors have voiced against the institution of capitated payment arrangements by HMOs.

A final issue is the belief among some health-care analysts that the PPMs are little more than an additional middleman in a health-care marketplace that is already bloated by layers of bureaucracy. Even when a physician joins a PPM, the HMO still sells the policies, provides the patients, and deals with insurance regulators.[14]

Independent Practice Associations

Practice management companies are facing strong competition for the allegiance of physicians by a variety of health-care arrangements, with many offering the same advantages that PPMs bring to physicians without some of the drawbacks that joining a PPM entails. Principal among these competing arrangements are the IPAs, which enable physicians to contract collectively with HMOs while allowing doctors to maintain their independence. Since the IPAs offer some of the same advantages as PPMs, they are viewed by Wall Street as a competitive threat to PPMs.[17] Nationally, 40% of all physicians participate in IPAs, although on average IPA contracts represent only 11% of a physician's total annual revenue.

Independent practice associations are legal entities that contract directly with physicians for the provision of services to HMO members. An IPA does not buy a doctor's practice as a PPM does, but instead offers to represent doctors when they do business with HMOs and other managed-care companies. The IPAs usually agree to do this in exchange for a percentage of revenue from contracts they negotiate. The company best known for taking this approach is FPA Medical Management, an IPA based in San Diego.[17]

Physicians associated with IPAs maintain their own offices and individual professional identities. Physicians remain free to provide medical care to patients not enrolled in the plans with which their IPA contracts. The IPA can contract with either groups of physicians or solo practitioners and can operate in a variety of different arrangements. An IPA may be hospital-based, community-based, or specialty-based. The reimbursement for an IPA comes directly from the HMO to the IPA, with the IPA in turn disbursing the funds to the physicians. Typically, primary-care physicians are capitated (prepaid), and specialty-care physicians are reimbursed on the basis of a percentage discount or on an acceptable "usual and customary" fee schedule for the services that are provided.[18] Many of the early IPAs were developed by organized medicine to compete with large closed-panel HMOs. These initial plans were often sponsored by local medical societies and were dubbed "foundations for medical care."[19]

In contrast to PPMs, the IPAs do not have an ownership role in affiliated practices. Physicians benefit when the IPA is able to negotiate profitable contracts on their behalf, but in most cases doctors do not benefit directly from the financial success of the IPA as a unit (however, there are situations in which the practice contracting with an IPA is capitated, and the doctors therefore benefit by any money in excess of the withhold). This is in contrast to a PPM, where doctors may own stock in the company and benefit directly when the company has increased profits. As a result, compared with PPMs, the IPAs have at their disposal fewer methods for directly influencing physician practice patterns. Moreover, the IPAs generally have invested less in the organizational infrastructure needed to market to HMOs. Furthermore, PPMs employ technology in an effort to reduce costs and streamline operations, while IPAs provide only modest value to participating physicians. Although there are examples of IPAs that have invested heavily in the same information technologies that PPMs routinely employ, this trend has so far been the exception. This is one of the reasons why investors are not as eager to provide capital to help finance IPAs, whereas PPMs seem to have no shortage of willing investors in the current market.

Despite the perceived advantages of PPMs, IPAs managed by independent companies with strong marketing and sales staffs have the potential to offer PPMs significant competition in the next

3 to 5 years. One obvious consideration that favors the IPA model is that it requires less start-up capital than a comparable PPM. With a smaller capital investment needed for start-up costs, IPAs can more rapidly consolidate hundreds of physicians in a region to bid for HMO contracts. In the long run, however, many IPAs are said to be at a disadvantage relative to PPMs because IPAs have demonstrated less ability to alter the operating efficiency of doctors.[13]

Management Service Organizations

Management service organizations provide administrative services to physicians but, unlike PPMs, have no claim on the revenues and assets of the practices under their umbrellas. Moreover, unlike an IPA, an MSO typically will not negotiate contracts on behalf of physicians; therefore, the MSO itself is not exposed to the financial risk of the medical practice.

An MSO is a legal corporation formed to provide practice-management services to physicians. Typically, an MSO is established and jointly owned by a hospital and a group of physicians. The MSO provides a wide and varying range of services, such as information systems, to networks of physicians who contract as a unit. The MSO receives either a set fee for the services it provides to physicians or a percentage of the doctors' revenues. Physicians often develop MSOs as an alternative to selling their practice to hospitals or PPMs. Physicians believe that operating their own MSO will allow them to hold onto their clinical and economic autonomy. In some cases, hospitals offer financial and management assistance in the hope that it will lead to future ties between the MSO and the hospital.[20]

Management service organizations affiliated with hospitals are privately held entities in which ownership is generally split 50/50 between the doctors and the hospitals. When MSOs are formed or supported by hospitals, often the hospital systems that commit to establishing the groups require physicians to sign a contract stipulating that they will remain with the MSO for a specified, typically extended length of time (anywhere from 10 to 40 years).

Criticisms of MSOs generally involve situations in which the organizations have exaggerated claims about their abilities to medical groups. Hospitals often tend to oversell MSOs, and physicians may end up disappointed. In many cases, doctors contend that the MSOs do not have much depth and fail to offer physicians many of the services that they need to be successful.[21]

The balance of power in the MSO, in terms of both equity and governance, may also be problematic. Physicians may have 50% of the equity in an MSO but only 30% of the governance, which means they will derive half of the profits from a venture but have little direct control over the manner in which it is administered. Health-care consultants typically advise doctors that when faced with a choice between equity and governance, they should take governance. The issue of control takes on importance for some doctors because MSOs are seen as a means to create a public company. Because MSOs are often the platform from which investment bankers launch publicly held PPMs, there are groups of doctors who want to own an MSO because they see it as a stock opportunity.[22]

Many hospitals that once considered launching MSOs have opted instead to form physician-hospital organizations, or PHOs. These are looser networks of physicians who band together with a hospital for the sole purpose of negotiating volume contracts. These organizations, like MSOs, allow hospitals and doctors to collectively market their combined services to HMOs. Analysts, however, regard these entities as essentially defensive in nature—that is, they are initiated to preserve the existing admissions of the affiliated hospital. As a result, there is an inherent conflict between the goals of the hospital, which is seeking to boost its occupancy, and the goals of the physicians, who could be rewarded by HMOs for reducing hospitalizations.[13]

Both physicians and hospitals complain that PHOs have rarely lived up to expectations because in many cases they lack the asset integration of physician practices, do not have true physician involvement, and have not obtained a sufficient number of managed-care contracts. The HMOs argue that the absence of primary-care physicians from a PHO's contracting network makes the PHO unattractive as a managed-care contracting entity.[23] Surveys have found that as many as 80% of hospitals that acquire doctor groups operate them at a loss. Given these trends, the question of how long PHOs can be sustained as an alternative to MSOs is unclear.[9]

As for MSOs, despite some shortcomings, these arrangements continue to proliferate. One reason is that onerous fraud and abuse restrictions have made MSOs one of the few remaining ways hospitals can legally affiliate with their physicians, although even these arrangements involve some legal pitfalls. These special arrangements are often crucial to the operational strategies of investor-

owned hospitals. In the past, for-profit hospitals had more leeway to offer special arrangements to physicians, such as joint ventures and attractively priced office space. Newer restrictions imposed on hospitals in many states now make such practices illegal.

Physician-Sponsored Organizations

Physician-sponsored organizations, an infant industry compared with the other entities discussed so far, are nonetheless likely to become a more prominent part of the future health-care marketplace. These organizations are essentially HMOs that are owned and operated by their physician-members. These networks usually include primary-care physicians as well as specialists. Because PSOs contract directly with employers, they eliminate the HMO intermediary between the employer (the purchaser of health-care services) and the provider or doctor. Three fourths of the 50 state medical societies are currently planning to form such organizations. Although antitrust laws have previously prevented the formation of these networks (doctors were barred from owning and operating their own health-care networks), in August 1996 the Federal Trade Commission and the Justice Department issued guidelines easing the previous restrictions imposed on the formation of physician-sponsored HMOs. This has cleared the way for growth in this sector.

Critics of PSOs contend that in most markets these organizations are not long-term competitors to traditional managed-care plans. One reason is that the PSOs generally lack start-up capital. The larger managed-care plans have the capital to form new networks almost overnight, but smaller hospitals and physician groups do not. Additionally, analysts say, PSOs may not be able to sustain losses in protracted price wars with larger HMOs (and may not even be able to sustain losses over a short period of time.)[24] The most a PSO can hope for, some critics contend, is to last long enough to be bought out by an HMO. This may be true in some instances, but is perhaps only wishful thinking on the part of Wall Street analysts in other cases. Since most PSOs are privately held, Wall Street investment houses have little to gain if the PSOs succeed in competing effectively with the for-profit HMOs and stem the growth of other publicly traded entities, such as PPMs.

A potential pitfall that remains for PSOs is the possibility of renewed government intervention. One unresolved issue is how the federal government is going to oversee PSOs. It seems clear that Congress will require federal oversight of some kind, perhaps federal licensing. Restrictive regulations that are costly to implement could well determine the future success of PSOs.

Summary

The health-care marketplace faces continued consolidation, and as a result, physicians are finding that they must band together to gain leverage in their negotiations with larger entities, such as hospitals and managed-care companies. This is prompting investor-owned health-care companies to propagate an extensive array of models for physician and hospital organizations. The future success of these organizations in a constantly changing marketplace is at best unclear, and how well these organizations will operate in the long run remains to be seen. In some cases, these organizations are returning economic power to physicians and giving them increasing strength at the bargaining table with HMOs. In situations in which physicians have controlling ownership of these new entities, they are gaining important economic influence in defining how they practice medicine. Finally, in those instances in which a physician has sold a practice or a clinic to an independent company and has become, essentially, an employee of that company, the physician has benefited financially. In the case of a PPM, doctors have received a lump-sum payment of between $250,000 and $750,000 when they sold their practices. However, these short-term gains are achieved only at the cost of relinquishing a significant portion of the long-term equity in their practices.[25]

At the other extreme are the PSOs, in which the doctors own and operate the HMO. These are the ultimate means by which doctors can control the contracting side of their business and preserve their clinical autonomy by controlling the equity. However, some PSOs have floundered, only to have larger managed-care companies acquire them. Restrictive government regulation of the PSOs and a lack of management expertise on the part of physician-owners have so far hampered the success of these groups.

Management service organizations provide valuable business services to doctors. In many markets, however, MSOs are losing contracts to PPMs. Managed-care companies prefer to negotiate with the PPMs, which, by virtue of their ownership in the practices of individual physicians, are viewed by HMOs as having a greater ability to influence how doctors practice

medicine, thereby reducing the costs of delivering care.

The PPM is currently the most popular model being duplicated in regions throughout the country. However, many of the same ethical concerns that arose with the spread of managed care continue to linger in the minds of those physicians who would consider joining PPMs. These new organizations may, in the end, be a double-edged sword. In some cases, PPMs are returning clinical and financial autonomy to physicians, many of whom have endured years of declining freedom to practice medicine independent of third-party intrusions. Even in these cases, however, doctors may eventually suffer the consequences of relinquishing a controlling interest in the PPM. The result may be that physicians risk enduring the same difficulties they faced at the hands of HMOs—that is, losing autonomy to a third party that is run, not by clinicians, but by financiers, who are often more focused on the short-term financial gains of a corporation than on the long-term health of patients.[26]

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