

The Group Practice Without Walls: Physicians Managing Managed Care

Thomas J. Rakowski, MD

Put the care of patients into the hands of financial people? Never!

Managed care replacing fee-for-service? No way!

Allow capitation to influence a physician's decisions? Forget it!

Until recently, these statements reflected the attitudes of many physicians toward managed care. As a medical oncologist who also practices adult internal medicine, I once held these same anti-managed care sentiments. I have been part of an established, six-doctor practice since 1981. Until very recently, our practice consisted entirely of patients covered by indemnity insurance and/or Medicare.

Only 6 months ago, our practice had no managed care contracts. Today, we have eight and are enlarging our coverage by entering into alliances with other group practices purely for the purpose of contracting with managed care organizations (MCOs). How—and why—did our practice travel such a great distance in such a short time? And how much further must it go? The answers have yet to be determined. However, we have learned from these changes that, if physicians are to maintain their influence in the delivery of health-care tomorrow, they must take an active role in managed care today.

Initial Attitudes

Many physicians resent and mistrust the concept of managed care, claiming they do not want financial concerns to govern health matters, or medical decisions made by those without medical training. I also did not want MCOs to intervene in the high-quality

care my patients received and reasoned that if I did not want an MCO to oversee my medical practice, I simply would not join one. But there was one problem our group and others continued to experience: no one wanted to pay for their healthcare anymore—not insurance companies, or patients, or employers. The inability to pay for healthcare can be traced to a variety of well-known factors, including unnecessary surgeries, extended hospitalizations, frivolous testing, resource overutilization, and aging demographics. What mattered more than these reasons, however, was the fact that managed care had arrived, and it became clear that the sooner physicians became involved in the decision-making processes, the sooner they would become a part of the power structure and create a healthcare system that worked best for all.

Early Warning Signs

Because managed care is not yet a truly national phenomenon, it is easy to ignore in certain areas of the country. Physicians in northeastern New Jersey, for example, certainly knew about managed care but felt immune because of the local conditions. The area consists of a stable population of affluent adult patients who can afford out-of-network or fee-for-service care. Because the patients are older, their relationships with their physicians are solid. Furthermore, there is no single major employer who might be able to effect managed care with a single stroke.

Despite all this apparent security, there were definite early warning signs. The region has many smaller employers and their healthcare costs were running 25% to 40% higher than those of larger firms. Consequently, more and more employers were forced to enroll in health maintenance organizations (HMOs). Concurrently, more and more local hospitals and physicians were contracting with MCOs, and MCOs were selectively contracting with providers. There was increasing availability in physician schedules, and some physicians were getting shut out of some HMOs.

The author is an attending physician at The Valley Hospital, Ridgewood, NJ, and Medical Director, Bruce Leeb & Co, Midland Park, NJ.

Address correspondence to: Thomas J. Rakowski, MD, Bruce Leeb & Co, 666 Godwin Avenue, Suite 300, Midland Park, NJ 07432.

Educational Seminars

In response to these developments, our hospital hired a consulting firm to assess the local market, determine the standing of the institution and staff, and make recommendations regarding the need to organize in response to the growing influence of managed care. At educational seminars held for the staff, what was learned completely changed most physicians' views on managed care. I personally learned that the best way to exert control over managed care is to become part of it. We may never get business people to start thinking like MDs, but it is clear that all physicians had better start thinking like business people—or at least those who want to stay in practice.

The educational seminars provided overwhelming evidence of how managed care had penetrated other parts of the country. It was shown that managed care markets evolved at paces that reflect the unique market forces of the area, and that once it made inroads, it grew very quickly.

The message was reinforced by a closer look at our own regional situation. A year previously, there was only about 5% penetration of managed care in the area. Just a year later, it had risen to 15%, and it is projected in five years to be 50%.

Our practice group decided to follow the direction of the hospital, that is, to become essential to the managed care market. Hospitals can get frozen out of managed care contracts just as physicians can, but our hospital became proactive by initiating steps to shorten lengths of stay and reduce costs. As a result, it was able to maintain its essential role in this catchment area.

The same principle holds true for physicians. To become essential to payers, physicians must have the wide geographic presence and large patient base that is crucial to MCOs. Such expansion levels the playing field, creating a situation of mutual need.

Group Practice Without Walls

Physicians can organize along a continuum of models that begins with the solo practitioner and ends with a group that forms its own HMO; that is, they eliminate the middleman (the MCO) and sell their services directly to employers. Our practice decided to link with several other practices consisting of like-minded physicians and form a Group Practice Without Walls (GPWW).

A GPWW consists of physicians linked for business reasons who usually operate from different offices. The different group practices within a GPWW bind together solely for the purpose of contracting with MCOs as a "unified provider." Although the individual practices within the GPWW continue to function as

entrepreneurial, they form a legal entity that contracts with MCOs as a unit. There are two basic types of legal entities a GPWW can become: (1) a corporation (which includes a professional corporation or a limited liability corporation); and (2) a full or limited partnership.

Once the legal structure of the GPWW is determined, the types of practices and physicians who will be included are determined. Most MCOs contract for a 50/50 split between primary care physicians and specialists. However, this ratio can vary according to the population served and the numbers and types of physicians available. In metropolitan areas, most

The Physician Hospital Organization

Our hospital organized a physician hospital organization (PHO) 7 years ago, during a time when most physicians were still practicing in the fee-for-service world and did not understand the importance of this entity. However, more recently, the wisdom of creating a PHO has become increasingly more apparent.

PHOs are joint ventures between physician groups and hospitals. The reasoning behind the PHO is simple: a hospital may have several different managed care contracts, but if local physicians are not contracted with these same MCOs, the hospital will not get their patients. On a similar note, a physician on hospital staff can have problems if his or her patients who are not members of a particular MCO cannot be admitted to the hospital. Patients suffer when local physicians and hospitals contract with different MCOs.

PHOs are growing rapidly, but because they are relatively new, most are single-hospital entities. PHOs that collaborate with other hospitals and form increasingly larger physician-hospital networks (those that cover larger geographic areas and greater numbers of patients) will be most attractive to MCOs.

If these new alliances between physicians and hospitals sound like businesses with products to sell, market niches to secure, and customers to target, they probably are. However, such business maneuverings will probably not continue forever. It is important that we physicians take some time now to restructure ourselves so that we can go back to what we were trained to do—provide quality medical care.

MCOs require that 80% to 90% of its physicians be board-certified. Finding board-certified physicians in metropolitan areas with whom to associate is not difficult but can be problematic in rural areas.

New members can be recruited by distributing documents describing the objectives of the GPWW. Meetings can be held to ensure that all members have the same goals and expectations and are fully informed of the processes being followed.

The financial, legal, and business expertise needed to create a GPWW is complicated. To save time and avoid unnecessary mistakes and setbacks, groups may decide to enlist the help of a management services organization (MSO) in forming a GPWW. An MSO can be an organization or individual who provides the necessary business and legal expertise needed to deal effectively with MCOs. The MSO helps to create the GPWW after all interested members have been identified.

Physician-Owned-and-Managed MCOs

The group we formed includes about 30 physicians and may eventually expand to include additional members. The past 2 years have seen tremendous growth in the number of physician groups like ours, and some physicians are creating much larger groups, avoiding MCOs entirely and selling their healthcare services directly to employers.

Starting a physician-owned MCO requires much more than the ability to provide good medical care. The organizers need the expertise to handle business decisions and the capital to finance the complex information systems required to project costs, monitor performance, and handle billing.

Examples of such groups abound: recently, 3,500 New Jersey doctors contributed \$5,000 each to raise the \$17.5 million needed to set up their own MCO; in 1994, 200 doctors in El Paso, Texas, formed the El Paso Community Health Plan and reached an agreement with a large local employer to treat job-related injuries; an 80-member group in Ohio formed the Holzer Clinic and has a contract with a major auto parts manufacturer; and the Mayo Clinic, a physician-run group, provides services for major employers in Iowa and Minnesota.

Summary

The recent growth of MCOs has changed the entire structure of healthcare delivery. The inroads made by MCOs during the past few years have been staggering. It is understandable that many physicians are reluctant to participate in managed care due in part to the preponderance of nonmedically trained decision makers in the industry, the ethical issues surrounding capitation and undertreatment, a perceived sense of security in geographic areas not yet reached by managed care, and an unwillingness to abandon traditional methods of running a practice. As more individuals and small businesses join HMOs, and other changes in the medical marketplace occur, such thinking must be eschewed in favor of a more receptive approach to the inevitable changes taking place. One way physicians can retain their influence in medicine while ensuring the delivery of quality care for their patients is to join together with professional unity in sizable organizations. Joining and forming groups like our GPWW is an absolute necessity for physicians who wish to continue to practice medicine successfully.