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Consolidation of Medical Groups Into Physician Practice Management Organizations

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Context.—Medical groups are growing and merging to improve efficiency and bargaining leverage in the competitive managed care environment. An increasing number are affiliating with physician practice management (PPM) firms that offer capital financing, expertise in utilization management, and global capitation contracts with health insurance entities. These physician organizations provide an alternative to affiliation with a hospital system and to individual physician contracting with health plans.

Objective.—To describe the growth, structure, and strategy of PPM organizations that coordinate medical groups in multiple markets and contract with health maintenance organizations (HMOs).

Design.—Case studies, including interviews with administrative and clinical leaders, review of company documents, and analysis of documents from investment bankers, the Securities and Exchange Commission, and industry observers.

Setting.—Medical groups and independent practice associations (IPAs) in California and New Jersey affiliated with MedPartners, FPA Medical Management, and UniMed.

Outcome Measures.—Growth in number of primary care and specialty care physicians employed by and contracting with affiliated medical groups; growth in patient enrollment from commercial, Medicare, and Medicaid HMOs; growth in capitation and noncapitation revenues; structure and governance of affiliated management service organizations and professional corporations; and contracting strategies with HMOs.

Results.—Between 1994 and 1996, medical groups and IPAs affiliated with 3 PPMs grew from 3787 to 25 763 physicians; 65% of employed physicians provide primary care, while the majority of contracting physicians provide specialty care. Patient enrollment in HMOs grew from 285 503 to 3 028 881. Annual capitation revenues grew from \$190 million to \$2.1 billion. Medical groups affiliated with PPMs are capitated for most professional, hospital, and ancillary clinical services and are increasingly delegated responsibility by HMOs for utilization management and quality assurance.

Comment.—Physician practice management organizations and their affiliated medical groups face the challenge of continuing rapid growth, sustaining stock values, and improving practice efficiencies while maintaining the loyalty of physicians and patients.

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MANAGED CARE is placing severe pressures on traditional forms of physician organization.¹ Many solo practices, single-specialty groups, multispecialty groups, and independent practice associations (IPAs) lack the scale to contract effectively with payers, to spread the financial risk of capitation payment, to manage the full spectrum of clinical services, and

to document the quality of their care. Increasingly, they are affiliating with larger organizations to achieve the financial strength and business sophistication needed to compete effectively in the new economic environment. In states with a high degree of physician organization, such as California, medical groups and IPAs are consolidating and contracting as single entities with health maintenance organizations (HMOs). In states where solo and small-group practices prevail, such as New Jersey, larger physician organizations are being built from the ground up.

Two types of organizations are competing for leadership in the consolidation of physician practice. In many communities, hospital systems are purchasing physician practices or forming physician-hospital organizations (PHOs) to contract with payers on behalf of both physicians and facilities.²⁻⁴ Recent years, however, have witnessed the dramatic growth of nonhospital physician practice management (PPM) organizations that coordinate medical groups in multiple markets.⁵⁻¹¹ These PPMs contrast with PHOs in being for-profit rather than nonprofit organizations, in obtaining financial capital from private investors rather than from tax-exempt bonds, and in contracting with multiple hospitals rather than being committed to the inpatient and outpatient facilities of a hospital owner. They are applying competencies in capitation finance and utilization management acquired in highly competitive markets to areas newly exposed to managed care. As the PPMs and their affiliated medical groups evolve from local to regional organizations, they are seeking statewide and ultimately national contracts with health plans.

This article reports results from an analysis of PPM organizations nationally and case studies of 3 prominent firms. It presents data on physician affiliations through employment and contracts, primary care and specialist physician mix, HMO patient enrollment, and capitation financing. It examines the evolution of ownership, governance, and contracting relationships and contrasts experiences in California, a state with many large medical groups, with those in New Jersey, a state dominated by solo practice.

DATA AND METHODS

Overview information on the PPM industry was obtained from the trade press, stock brokerages, and investment banking reports. Information on individual firms was obtained from annual reports and other company documents; company filings with the Securities and Exchange Commission for equity and bond offerings; reports by independent stock analysts and by investment bankers that market securities for the firms; interviews with

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key managerial and clinical leaders in the PPMs and their affiliated medical groups; and interviews with leaders in unaffiliated medical groups, health plans, and other organizations. Information elicited from the documents and interviews focused on ownership, governance, and contractual relationships between the management services organizations (MSOs) and professional corporations (PCs); structure and consolidation of contracts with HMOs; and strategies for growth via mergers, acquisitions, and obtaining new contracts for affiliated medical groups.

Individual firms were selected for case studies based on several criteria. They are focused on growth through acquisition of existing medical groups and development of new physician networks in multiple markets. They embrace managed care as their primary source of patients and revenues, and hence seek capitation and delegation of responsibility for utilization and quality management. They relate to hospitals primarily through contractual rather than ownership ties, contrasting thereby with PHOs, nonprofit medical foundations, and other hospital-based systems. Firms were excluded if they focused on a single specialty (eg, oncology) or if they were owned by a health plan.

Three firms were selected based on these criteria. MedPartners (Birmingham, Ala) is the nation's largest PPM organization, with operations in 36 states and affiliations with leading multispecialty groups as well as networks of smaller groups and IPAs.¹²⁻¹⁵ FPA Medical Management, San Diego, Calif, traditionally has focused on the organization of primary care physicians into IPAs and is now affiliating with integrated medical groups in California, the Southwest, and along the Atlantic seaboard.¹⁶⁻²¹ Both MedPartners and FPA are publicly traded firms with ownership shared by senior management, affiliated physicians, and outside investors. UniMed (Burbank, Calif), the for-profit subsidiary of a nonprofit hospital system (UniHealth America), is seeking private investors and contemplating a public stock offering to finance a national expansion.²² It represents the devolution of a PHO into a holding company structure where the physicians and hospitals contract with each other on a non-exclusive basis rather than seek to create a vertically integrated system.²³

RESULTS

Growth Through Mergers and Acquisitions

MedPartners, FPA, and UniMed have grown very rapidly in the past 2 years through mergers and acquisitions of existing medical groups and IPAs. Table 1 presents data on physicians employed by medical groups affiliated with the 3 firms

Table 1.—Primary Care and Specialty Physicians Affiliated With 3 Physician Practice Management Firms, 1994 to 1996*

	MedPartners	FPA	UniMed	Total
Physicians employed in affiliated groups				
Primary care				
1994	65	0	101	166
1996	1701	377	334	2412
Specialty care				
1994	125	0	94	219
1996	902	120	279	1301
Physicians contracting with affiliated IPAs				
Primary care				
1994	0	1056	879	1935
1996	5314†	4040	1487	10 841†
Specialty care				
1994	0	300	1167	1467
1996	5314†	6670	4542	16 526†
Total affiliated physicians				
1994	190	1356	2241	3787
1996	7914	11 207	6642	25 763

*Data do not include hospital-based physicians affiliated through Team Health (MedPartners) and Sterling Healthcare (FPA).

†In December 1996 MedPartners had 5314 physicians in affiliated independent practice associations (IPAs); it does not maintain information on primary care vs specialty care training for contracting physicians.

and on physicians who contract with affiliated IPAs. Between the fourth quarter of 1994 and the fourth quarter of 1996, MedPartners grew from 190 physicians, all of whom were employed, to 7914 physicians, 33% of whom were employed and the remainder of whom contract with affiliated IPAs. FPA grew from 1356 contracting physicians in 1994 to 10 710 contracting and 497 employed physicians in 1996. Medical groups and IPAs affiliated with UniMed employed 195 physicians and contracted with 2046 physicians in 1994; in 1996 they employed 613 physicians and contracted with 6029.

The distribution of affiliated physicians by employment and contract status and by primary care and specialty care training differs among the 3 PPM firms depending on their geographic concentration and strategic focus. MedPartners and UniMed have merged with and acquired prominent multispecialty medical groups. One third of all their affiliated physicians are employed by PCs exclusively affiliated with the PPMs. In contrast, FPA has focused on building and acquiring IPAs, with the result that 96% of its physicians retain ownership of their practices and contract with FPA-affiliated IPAs. All 3 PPMs maintain a primary care focus in their affiliated medical groups, with the result that the majority of employed physicians have primary care training. This primary care emphasis is much stronger in FPA than in MedPartners and UniMed, however.

MedPartners was established in 1993 but was still focused on networks of small practices in the Southeast when it made its initial public stock offering in February 1995. In November of that year it merged with Mullikin Medical Enterprises, a leading physician organization with 400 employed physicians, 2600 IPA physicians, and 360 000 capitated HMO

patients in California, Oregon, and Washington.²⁴ In February 1996 it acquired Pacific Physician Services, a publicly traded PPM with a network of medical groups and 300 000 capitated HMO patients in California and Arizona.²⁵ In September of that year it acquired Caremark International, a diversified corporation that managed 7 large multispecialty medical groups, including the Kelsey-Seybold clinic in Houston, Tex; Oklahoma City Clinic in Oklahoma City, Okla; North Suburban clinic in Chicago, Ill; and Friendly Hills HealthCare Network in La Habra, Calif.²⁶ Friendly Hills, with 144 physicians and 100 000 capitated HMO patients, had joined Caremark after becoming disenchanted with what it perceived to be the nonentrepreneurial culture of the PHO it had helped create.²⁴ Caremark and Friendly Hills then acquired the staff-model component of the CIGNA health plan in California, with 251 physicians and 289 000 capitated patients. Mullikin was itself partly based on the staff-model component of the Maxicare health plan in Los Angeles, Calif. In March 1997 MedPartners announced the acquisition of Aetna Professional Management Corporation, the staff-model component of Aetna Healthcare, which owns 47 HealthWays Family Medical Centers, employs 189 physicians, and manages 6 IPAs with 800 contracting physicians.²⁷ In June it completed a merger with InPhyNet, a PPM company with 116 000 HMO patients in Florida.²⁸ In August it announced the acquisition of Talbert Medical Management, the former staff-model component of FHP International, which operates 52 clinics with 252 physicians and 270 000 patients in 5 western states.²⁹ In October MedPartners announced it would be acquired by the PhyCor PPM (Nashville, Tenn). The combined company will be affiliated with

35 000 employed and IPA physicians, provide capitated services to 3 million HMO patients, and earn \$8.4 billion in annual revenues from operations in all 50 states.

FPA Medical Management began as a primary care medical group in San Diego, Calif, in 1986, made an initial public stock offering in October 1994, and began a rapid expansion through acquisition and creation of IPAs in Arizona, Texas, and the Delaware Valley. In 1996, it purchased or developed IPAs in Florida, California, Delaware, New Jersey, South Carolina, and North Carolina. It acquired the staff-model clinics of the PCA health plan in Florida, with 70 employed physicians and 90 000 patients, the Foundation Health staff-model clinics in California, with 73 employed physicians and 89 000 patients, and the Thomas-Davis Medical Group (also owned by Foundation Health), with 231 physicians and 90 000 HMO patients in Arizona. When acquiring the clinics, FPA signed long-term contracts with the HMOs guaranteeing that it will continue providing services to their enrollees: a 10-year contract with PCA and a 30-year contract with Foundation Health. In March 1997 it completed the acquisition of AHI, a publicly traded PPM with 200 000 HMO patients in California, Florida, and Texas. In July it announced the acquisition of Health Partners, a PPM with 138 000 HMO patients in New York, and the signing of long-term agreements with its previous owners, Oxford Health Plans and WellPoint Health Networks.³⁰ In August it announced the acquisition of the clinic network of Prudential HealthCare in North Carolina and the signing of a 10-year globally capitated contract covering 27 000 enrollees with that health plan.³¹

UniMed originated in the attempt of the UniHealth hospital system to develop a vertically integrated PHO in Los Angeles.³² UniHealth acquired the Facey and Harriman-Jones medical groups geographically adjacent to its hospitals in San Fernando and Long Beach and began to convert them to nonprofit health care foundations. It became disenchanted with the physician productivity declines and the internal conflicts between physician and hospital components of its system, however, and evolved into a holding company with separate hospital and professional services divisions. The UniMed professional services division has subsequently grown rapidly through the acquisition of the Huntington Provider Group, an IPA that now covers 400 000 HMO patients throughout the Los Angeles area, the Beaver Medical Group in southeastern California, and the San Jose, Good Samaritan, and Redwood Empire medical groups in northern California. None of these subsequent ac-

quisitions were made in areas adjacent to UniHealth hospitals. Even where UniMed medical groups and IPAs are within admitting distance of UniHealth facilities, the physicians can admit to the hospital of their choice. The UniMed medical groups are no longer expected to contract at higher rates with the UniHealth hospitals than are charged to unaffiliated medical groups. UniMed recently converted to for-profit status and is seeking private investors to obtain capital for expansion outside California. It has been approached by investment bankers offering to manage a public equity offering. Historically, its capital has come from sale of stock from PacificCare Health Systems, an HMO in which UniHealth owns a large minority stake.

The strategy and methods used by PPMs to acquire medical groups and IPAs can be illustrated using UniMed as an example. The quantitative core of the method used to assess potential medical groups and IPAs for affiliation includes current patient enrollment and capitation rates for every commercial and Medicare HMO; tangible assets such as buildings, computer systems, and clinical equipment; financial assets and liabilities; revenue and earnings history; and discounted future earnings projections. UniMed also examines the competitive position of each medical group and IPA in its local market. Extensive effort is devoted to assessing the local context in terms of other physician organizations, PHOs, and managed care penetration. It assesses local supply costs from vendors of inpatient and ancillary services and fee schedules for outside contracting physicians. The governance structure is very important, and is evaluated in terms of number of physician shareholders, physician participation in business and clinical management, and the percentage of primary care physicians who have an exclusive relationship rather than participate in multiple IPAs.³³

Ownership Structure and Governance

Physician practice management firms typically own an MSO that acquires the physical facilities of physician practices, employs the nonphysician staff, and manages the business operations of the clinics and of affiliated IPAs. The MSO contracts with 1 or more PCs that are owned by physician shareholders and that employ the physician members of medical groups and contract with the physician members of IPAs. The PCs make the decisions concerning physician hiring and firing, physician compensation, and clinical matters such as utilization management and quality assessment. The MSO employs the administrative staff that supports the PC's activities, however. The MSO and PC sign an exclusive manage-

ment services agreement with a long-term structure, typically 30 or 40 years.

The PPMs manifest a variety of ownership structures. Some are wholly owned subsidiaries of hospital systems or, with decreasing frequency, of HMOs. Some are owned by large independent medical groups such as the HealthCare Partners Medical Group in Los Angeles. The largest PPMs, including MedPartners and FPA, are owned by public shareholders in addition to their senior management and affiliated physicians. Senior management and corporate directors own approximately 9.4% of the outstanding shares at MedPartners and 17.1% of outstanding shares at FPA.^{14,21} Investment analysts and finance economists typically interpret significant ownership shares as a positive indicator of management commitment to growth in firm size and value.³⁴

Publicly traded PPMs encourage equity ownership on the part of affiliated physicians. MedPartners offers stock options at below-market rates to physicians employed in affiliated medical groups and to physicians who contract exclusively with an affiliated IPA. FPA uses equity to reward primary care physician commitment to affiliated IPAs. Attractive stock options are offered to primary care physicians who have been affiliated at least 1 year, who have more than 500 HMO patients through the IPA, who meet resource efficiency criteria (inpatient days per 1000 enrollees, hospital readmissions, and specialty referral costs), and who meet quality-of-care criteria (patient satisfaction scores, patient access to nonurgent, urgent, and emergency care; chart audits; and performance on clinical indicators). One important reason UniMed converted to for-profit status and is considering a public stock offering is to be able to offer ownership options to its affiliated physicians. Lack of physician commitment is often cited as a reason for poor economic performance at PHOs.³⁵

The MSOs and PCs typically share responsibility for contracting with health plans. In many states, the PCs hold the payer contracts, but the MSO staff play central roles in negotiations. California has decided to directly license large physician systems to contract with HMOs for global capitation payment, in contrast with the previous structure that permitted medical groups only to be capitated for professional services and required them to join with hospital systems if they wished to share in capitation for inpatient services. The newly licensed entities are not PCs, but are subsidiaries of the PPMs. They are prohibited from contracting directly with employers. Both MedPartners and FPA have developed these licensed entities and UniMed has submitted an application to California for approval.

HMO Patient Enrollment and Capitation Revenue

Table 2 documents the rapid growth in HMO patient enrollment in medical groups and IPAs affiliated with MedPartners, FPA, and UniMed. In 1994, UniMed had 250 927 capitated patients, of which 27 824 were Medicare HMO enrollees and the remainder were enrollees in commercial HMOs. In 2 years, total enrollment tripled to 777 796, with almost 100 000 coming from Medicare. Rates of HMO enrollment have been even more dramatic at MedPartners and FPA, given the low base on which they began. In 1994, MedPartners consisted of fee-for-service medical practices in the Southeast and had no HMO patients. By the end of 1996 it had 1 629 655 capitated enrollees, including 116 854 Medicare beneficiaries and 177 830 Medicaid beneficiaries. FPA had 34 576 HMO enrollees in 1994 and by the end of 1996 had 621 430, of which 46 712 came from Medicare and 123 048 from state Medicaid programs. Enrollment growth in the 3 organizations was achieved primarily through mergers and affiliations and secondarily through addition of new physicians, contracts, and patients at existing affiliates.

The HMO patient enrollment of all 3 PPMs is disproportionately concentrated in California, given the origin of many of the affiliated medical groups in that heavily penetrated state, but the degree of concentration is declining as the PPMs develop a broad national presence. While 88% of FPA's prepaid enrollment was in California in 1994, only one third was there in 1996. In 1996, 80% of MedPartners' capitated enrollment was in California, but the major growth in 1997 is occurring in the Southeast and mid Atlantic states through the acquisitions of InPhyNet and the Aetna staff-model clinics and IPAs. Each of the PPMs is seeking to obtain a large share of physician affiliations and HMO patient enrollment in the communities where they operate. This is rapidly being achieved in California. In 1996 there were 14 million HMO enrollees in that state, of which 5 million were members of the Kaiser Permanente HMO. Of the non-Kaiser HMO enrollees, 14.7% were enrolled in medical groups affiliated with MedPartners, 2.4% in groups affiliated with FPA, and 8.8% in groups affiliated with UniMed. The market shares are significantly larger in the metropolitan areas of emphasis for particular firms: Los Angeles and adjacent counties for MedPartners, San Diego and Sacramento for FPA, and the Los Angeles and San Francisco region for UniMed.

Table 3 presents data on capitation and fee-for-service revenues at MedPartners, FPA, and UniMed for 1994 and 1996. UniMed doubled its total operat-

Table 2.—Health Maintenance Organization (HMO) Patient Enrollment in Medical Groups and Independent Practice Associations Affiliated With 3 Physician Practice Management Firms, 1994 to 1996

	MedPartners	FPA	UniMed	Total
Commercial HMO patients				
1994	0	26 100	223 103	249 203
1996	1 334 971	451 670	678 149	2 464 790
Medicare HMO patients				
1994	0	3443	27 824	31 267
1996	116 854	46 712	99 647	263 213
Medicaid HMO patients				
1994	0	5033	0	5033
1996	177 830	123 048	0	300 878
Total HMO patients				
1994	0	34 576	250 927	285 503
1996	1 629 655	621 430	777 796	3 028 881

Table 3.—Capitation and Fee-for-Service Revenues for 3 Physician Practice Management Firms, 1994 to 1996

	MedPartners	FPA	UniMed	Total
Capitation revenue, in \$1000				
1994	0	18 193	172 000	190 193
1996	1 401 837	267 642	412 875	2 082 354
Fee-for-service and other revenue, in \$1000				
1994	75 177	243	15 000	90 420
1996	1 153 805	172 677	37 125	1 363 607
Total operating revenue, in \$1000				
1994	75 177	18 436	187 000	280 613
1996	2 555 642	440 319	450 000	3 445 961

ing revenues, from \$187 million to \$450 million. Revenue growth was especially dramatic at MedPartners, which grew from \$75 million to \$2.6 billion, and at FPA, which grew from \$18 million to \$440 million. These figures do not include revenues from the pharmacy benefit management and disease management programs at MedPartners or the hospital and HMO divisions of UniMed's parent company UniHealth America.

All 3 PPMs are seeking to increase the percentage of revenues that come through capitation contracts, since the firms are large enough to bear the financial risks that attend capitation and can benefit from the ability to shift utilization and expenditures across different sites and styles of care, including physician offices, hospitals, subacute facilities, skilled nursing facilities, rehabilitation facilities, and home health settings. Almost all the HMO contracts capitate the medical groups and IPAs for primary care and specialty care physician services.³⁶ Increasingly, the PPMs are able to negotiate contracts capitating inpatient hospital, outpatient hospital, and ancillary services as well. The larger medical groups and IPAs have negotiated shared risk and, in some cases, full capitation contracts for pharmacy benefits. UniMed receives 92% of its total revenues from capitation, and will increase this percentage when it is licensed to contract for capitated hospital services. The percentage of revenue derived through capitation contracts in 1996 was somewhat lower at MedPartners (55%) and FPA (61%), illustrating their geographic scope

beyond the capitated California context. MedPartners and Aetna U.S. HealthCare recently announced the signing of the first national contract between a physician organization and a health plan.²⁷ This 10-year contract covers all MedPartners medical groups and IPAs and all Aetna lines of business (eg, HMO, Point-of-Service, and indemnity). FPA subsequently signed a national contract with Foundation Health Systems, an HMO with 3.1 million enrollees, of which 340 000 are currently served by FPA-affiliated physicians.³⁷ Other national health plans, such as PacifiCare and CIGNA, are entering into analogous contracts.^{38,39}

Physician Organization in New Jersey

Many of the nation's major PPM firms, including the 3 included in this study, developed in states where health plans and physicians were familiar with managed care. They face new challenges in moving into states where capitation payment and utilization management are embryonic, where health plans contract with physicians as individuals rather than as members of medical groups, and where hospital systems are purchasing the practices of many physicians. Both MedPartners and FPA are actively developing affiliations in New Jersey, a strategically located state whose medical markets overlap with those in New York and Philadelphia. Their experiences highlight the challenges facing any organization seeking to consolidate physician practices in an evolving managed care market and the

strategies particular organizations and groups of physicians can adopt in responding to those challenges.

FPA is affiliated with 2 IPAs in New Jersey, which together include 600 primary care physicians and 28 000 enrollees from the Oxford, MetraHealth, NYL-Care, and Blue Cross Blue Shield HMO and Point-of-Service plans. Each IPA has a board of directors and medical management committee composed of practicing primary care physicians and FPA staff. Specialty care physicians contract as individuals with the MSO rather than belong to the IPA, and do not play a major role in governance. FPA views its mission as the organization and empowerment of primary care physicians and interprets specialist-oriented PHOs as its main competitors. It adopts a cooperative stance to HMOs, which it interprets as major customers rather than as competitors.

Primary care physicians are paid by the IPA on a capitated per-member-per-month basis for the services they provide, with additional fee-for-service payment for selected procedures that can be performed directly or referred to a specialist (eg, sigmoidoscopy). These fee-for-service payments account for only 3% of the typical primary care physician's revenue from FPA. The primary care physicians are also eligible for a bonus based on number of patients obtained through the IPA (panel size), physician longevity with the IPA, referral costs, and performance on quality indicators. These bonuses account for 11% of the typical physician's revenue from FPA. To attract primary care physicians to join the IPA, FPA sets the base capitation rates significantly above those paid by local HMOs contracting with physicians as individuals.

Some HMOs in New Jersey are reluctant to delegate to the IPAs responsibility for utilization management, physician credentialing, and quality assurance. Health plans are willing to capitate medical groups and IPAs for primary care, specialty care, and hospital services, albeit with mental health and pharmacy "carve-outs," but are unsure whether those provider organizations are the proper candidates to manage the process of care. Medical groups in New Jersey lack a tradition of responsibility for utilization management, which has been imposed from outside by health plans. This contrasts with managed care in California, where capitation and delegation of utilization management go hand in hand.⁴⁰ FPA is unwilling to contract with a health plan that will not work toward delegation of these functions to the IPAs. It conducts a more stringent process of utilization management than most health plans, requiring authorization for nonemergency specialty referrals as well as hospitalizations. It is

developing internal medicine and pulmonology teams to coordinate medicine, surgery, and specialty procedures at major hospitals, allowing the primary care physicians to focus on outpatient services.⁴¹ It seeks delegation by HMOs of responsibility for documenting quality of care to purchasers, such as through the guidelines established by the National Committee on Quality Assurance.⁴² FPA interprets its greatest challenge as developing primary care physician leadership in an environment traditionally dominated by specialists and tertiary care hospitals.

MedPartners has affiliated with the Summit Medical Group, a multispecialty partnership with 81 physicians practicing in 7 locations in northern New Jersey. Summit covers 26 000 prepaid patients from Oxford, Aetna U.S. Healthcare, CIGNA, PHS, MetraHealth, and Prudential, which together account for one fourth of all patient revenue. In 1994, Summit embarked on a strategic planning process because of concerns with the rapid growth of managed care and consolidation among health plans in the New Jersey and New York markets. It rejected offers from hospital systems that, in its opinion, maintained a strategy for fighting managed care rather than a strategy for succeeding at managed care. It selected MedPartners in large part because of the PPM's strong affiliations with multispecialty medical groups in California, which possessed the skills in capitation budgeting and utilization management that the Summit physicians viewed as essential for continued growth in their market. The leaders in the Summit Medical Group had developed strong ties to Mullikin Medical Centers and other MedPartners-affiliated organizations within the American Medical Group Association.

Prior to affiliating with MedPartners, Summit Medical Group owned an MSO to provide business services to its PC. MedPartners purchased this MSO, the clinic facilities, and all equipment, but not the PC, with which it has signed a long-term exclusive contract. It employs the non-physician staff, including the top administrator of Summit, who is now a regional vice president of MedPartners with responsibilities for continued network growth. MedPartners seeks to double the size of the patient base, both by expanding the number of primary care physicians employed at Summit and by developing an affiliated IPA. The Summit PC is responsible for physician hiring and compensation and for decisions over which clinical services to offer and how many hours member physicians are expected to work. Individual physicians have an employment relationship with the PC and no direct relationship with the MSO. A joint advisory board, with equal membership

from the MSO and the PC, is responsible for strategic planning, capital budgeting, and payer contracting. The PC holds the payer contracts.

As an integrated medical group, Summit is delegated responsibility by all HMOs for referrals by its primary care physicians to its inside employed specialists. Contractual responsibilities vary, however, for referrals that go to outside contracted specialists. Some plans capitate Summit for all professional services and delegate utilization management for all referrals, while others capitate only for within-group referrals or require that out-of-group referrals be subjected to utilization review by the health plans themselves. The general trend is toward increased delegation of these functions. In contrast to capitated medical groups in California, Summit has not developed its own network of outside specialists, but relies on the networks developed by the HMOs. Summit has developed an extensive data information system that tracks all referrals both inside and outside the group, regardless of whether the medical group or the HMO is responsible for review. Under the terms of the HMO contracts, patients can choose to be referred to any specialist in the HMO network, but Summit encourages its primary care physicians to refer to specialists within the group. As part of a concerted effort to develop internal utilization management capabilities, referrals to outside specialists have been reduced from 30% to 18% of total referrals in the past 2 years.

COMMENT

Public and private purchasers of health care are imposing 2 demands on the health care system that are exerting dramatic effects on physicians and physician organizations. Purchasers maintain a continuing pressure to contain cost inflation despite the fact that the easiest savings from reduction in inessential care already have been obtained. Purchasers also are demanding that health plans offer broad networks of physicians to accommodate consumer desires for enhanced choice, despite the fact that narrow networks have traditionally been the means by which HMOs achieved price discounts and cost efficiencies. These purchaser demands are disadvantaging health care organizations that focused on cost control at the expense of broad networks or on broad networks at the expense of cost control. Staff-model HMOs are finding their narrow networks difficult to market and are increasingly divesting their owned physician groups and contracting on a non-exclusive basis with independent physician systems. Some IPA-model HMOs are finding it difficult to elicit further cost reductions from their broad net-

works of individual providers and are contracting with medical groups that can better coordinate physicians.

Two forms of organization are competing to develop health care delivery systems in this challenging environment: PHOs and PPM firms. The most successful PHOs have a strong local presence and reputation, capital resources from hospital profits and tax-exempt bonds, and existing ties with physicians through hospital medical staffs.^{43,44} The most successful PPMs have competencies in capitation and utilization management built by leading medical groups, maintain access to financial capital through public equity markets, and are not burdened by responsibility for excess hospital capacity. Physician-hospital organizations tend to be nonprofit in ownership, built on a tradition of community service, and dominated by specialist physicians and hospital management. Physician practice management organizations tend to be for profit in ownership, built on a tradition of physician entrepreneurship, and dominated by primary care physicians and corporate management.

References

1. Kletke PR, Emmons DW, Gillis KD. Current trends in physicians' practice arrangements: from owners to employees. *JAMA*. 1996;276:555-560.
2. Burns LR, Thorpe DP. Trends and models in physician-hospital organization. *Health Care Manage Rev*. 1993;18:7-20.
3. Shortell SM, Gillies RR, Anderson DA. New world of managed care: creating organized delivery systems. *Health Aff (Millwood)*. 1994;13:46-64.
4. Morrissey MA, Alexander J, Burns LB, Johnson V. Managed care and physician/hospital integration. *Health Aff (Millwood)*. 1996;15:62-73.
5. Rosenbluth JM. *Group Practice Management*. San Francisco, Calif: Volpe, Welty, and Co Equity Research; October 1993.
6. O'Neil BG, Manderfeld TB. *Physician Practice Management: Just What the Doctor Ordered*. Minneapolis, Minn: Piper Jaffray; August 1995.
7. Marsch LC, Weber MJ. *1995 Physician Medical Management and Services Report*. Philadelphia, Pa: Wheat First Butcher Singer, Investment Research Department; August 1995.
8. Kerms EH, Ockers NT. *Physician Practice Management: Consolidating Physicians to Manage Care*. Baltimore, Md: Alex Brown Health Care; January 1996.
9. Hewitt CL, Abramowitz KS. *Physician Practice Management: Consolidating Physicians to Manage Care*. New York, NY: Bernstein Research; December 1996.
10. Cain JE, Beith C, Deskin RB, Hollis SR. *The Best of the Breeds: A Comparison of Alternative Physician Practice Models*. New York, NY: Cain Brothers & Co; May 1996.
11. Laudan KR, Miller K, Johnson J. *The Physician Practice Management Industry and Company Update: Physicians Regroup and Take Stock*. San Francisco, Calif: Hambrecht & Quist; February 1996.
12. Moerschel G, McGuinnis P. *MedPartners, Inc.* Chicago, Ill: The Chicago Dearborn Co; December 1996.
13. MedPartners. *Prospectus for 7 and 3/4% Senior Notes Due 2006*. Birmingham, Ala: MedPartners; October 1996. Public securities offering sponsored by Smith Barney, Merrill Lynch, J.P. Morgan, Morgan Stanley, NationsBank Capital Markets.
14. MedPartners. *Prospectus for Common Stock*. Birmingham, Ala: MedPartners; October 1996. Public equity offering, New York Stock Exchange.

Physician practice management organizations face 3 major challenges in the increasingly competitive health care environment. First, they must continue their growth in physician affiliations, patient enrollment, and capitation revenues to sustain the confidence of investors and the value of their equity. This growth is achieved through new medical group acquisitions, new health plan contracts, and the attraction of new patients to already affiliated groups. "Same store growth" is a significant factor in evaluations by investment analysts, which influence the value of publicly traded PPM stock. This stock supplies the currency with which major mergers and acquisitions are financed and its price determines whether rapid growth is affordable.

The second challenge facing regional and national physician systems is to improve the economic efficiency, customer service, and clinical quality of the care offered through their affiliated medical groups and IPAs. Much of PPM growth is premised on the potential for a transfer of best business practices and clinical innovations from well-established medi-

cal groups to newer entities in communities only recently exposed to cost control pressures. These improvements are difficult to implement in a context of rapid organizational growth yet are essential for long-run profitability.

The third and greatest challenge facing PPMs is to make the needed changes in organization, financing, and practice patterns without undermining the confidence and commitment of the individual physicians affiliated with their medical groups and IPAs. The large organizational scale that brings better health plan contracts and more advantageous capital financing may threaten the sense of participation and control at the grass roots level. Insurance entities and hospitals that sought to create integrated delivery systems through practice acquisitions often have been plagued by low physician productivity. As they grow and consolidate, medical groups face the imperative to forge a culture that combines managerial efficiency and professional dedication.

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15. MedPartners/Mullikin. *1995 Annual Report*. Birmingham, Ala: MedPartners; 1996.
16. Kroll EE, Murphy KB. *FPA Medical Management, Inc.* New York, NY: Furman Selz; November 1996.
17. Wilson GL, Russ CS. *FPA Medical Management, Inc.* New York, NY: Lehman Brothers; November 1996.
18. Wiberg E, Ameer S. *FPA Medical Management, Inc.* New York, NY: UBS Securities; July 1996.
19. FPA Medical Management. *Value in Healthcare, 1995 Annual Report*. San Diego, Calif: FPA Medical Management; 1996.
20. FPA Medical Management. *Offering Memorandum, 6 and 1/2% Convertible Subordinated Debentures Due 2001*. San Diego, Calif: FPA Medical Management; December 1996. Public securities offering sponsored by Smith Barney, Bear Stearns, Lehman Brothers, Oppenheimer and Company, Neeham and Company.
21. FPA Medical Management. *Prospectus, Common Stock*. San Diego, Calif: FPA Medical Management; November 1995. Public equity offering sponsored by Bear, Stearns, Oppenheimer and Company, Hambrecht and Quist.
22. UniHealth. *Report to the Community, 1995*. Burbank, Calif: UniHealth; 1996.
23. Robinson JC, Casalino LP. Vertical integration and organizational networks in health care. *Health Aff (Millwood)*. 1996;15:7-22.
24. Robinson JC, Casalino LP. The growth of medical groups paid through capitation in California. *N Engl J Med*. 1995;333:1684-1687.
25. Robinson JC. The dynamics and limits of corporate growth in health care. *Health Aff (Millwood)*. 1996;15:155-169.
26. O'Neil BG, Manderfeld TB. *MedPartners*. Minneapolis, Minn: Piper Jaffray; December 1996.
27. MedPartners, Inc. to acquire Aetna U.S. Healthcare's physician practice management business; companies enter into strategic national provider relationship [press release]. Birmingham, Ala: MedPartners; March 5, 1997.
28. MedPartners, Inc and InPhyNet complete merger [press release]. Birmingham, Ala: MedPartners; June 26, 1997.
29. MedPartners announces acquisition of Talbert

- medical management [press release]. Birmingham, Ala: MedPartners; August 14, 1997.
30. Rundle RL. FPA plans to buy Health Partners for \$115 million. *Wall Street Journal*. July 3, 1997:B6.
31. FPA Medical Management, Inc announces agreements with Prudential HealthCare and Carolina Health Care Group [press release]. San Diego, Calif: FPA Medical Management; August 5, 1997.
32. Robinson JC. The dynamics and limits of corporate growth in health care. *Health Aff (Millwood)*. 1996;15:155-169.
33. Schenk RL. The independent practice association in theory and practice. *JAMA*. 1995;273:1937-1942.
34. Jensen MC. Eclipse of the Public Corporation. *Harvard Bus Rev*. 1989;67:61-74.
35. Medimetrix. *A National Initiative: The Survey of Hospital-Sponsored Management Service Organizations*. Cleveland, Ohio: Medimetrix; 1997.
36. Gold MR, Hurley R, Lake T, Ensor T, Berenson R. A national survey of the arrangements managed care plans make with physicians. *N Engl J Med*. 1995;333:1678-1683.
37. FPA Medical Management, Inc and Foundation Health Systems, Inc enter into letter of intent for national HMO contract [press release]. San Diego, Calif: FPA Medical Management; May 1, 1997.
38. FPA Medical Management, Inc signs agreement for national contracts with PacifiCare Health Systems [press release]. San Diego, Calif: FPA Medical Management; May 21, 1997.
39. FPA Medical Management, Inc signs new agreements with HealthSource, Inc [press release]. San Diego, Calif: FPA Medical Management; July 9, 1997.
40. Kerr EA, Mittman BS, Hays RD, Siu AL, Leake B, Brook RH. Managed care and capitation in California: how do physicians at financial risk control their own utilization? *Ann Intern Med*. 1995;123:500-504.
41. Wachter RM, Goldman L. The emerging role of hospitalists in the American health care system. *N Engl J Med*. 1996;335:514-517.
42. Iglehart JK. National Committee for Quality Assurance. *N Engl J Med*. 1996;335:995-999.
43. Shortell SM, Gillies RR, Devers KJ. Reinventing the American hospital. *Milbank Q*. 1995;73:131-160.
44. Robinson JC. Physician-hospital integration and the economic theory of the firm. *Med Care Res Rev*. 1997;54:3-24.