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The Future of Women's Care Organizations

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Single specialty medical groups are growing in popularity as physicians--and investors--develop a clearer understanding of their business potential. Numerous market factors are driving physicians to form and join these groups, and the resulting influence of a large number of like-minded, same-specialty physicians is significant.

Predictably, the face of managed medical care contracting is changing as these groups begin to speak and negotiate as one. More importantly, the business of medicine is forever changing as the aggregated earning power of high income producers gets leveraged into product and service diversification that are leaving traditional individual medical practices feeling dazed, confused and relatively impotent. The pressure to join these groups as they form and grow is enormous. The business of healthcare has compelled insurance executives to search for the economies of scale, available from larger groups and thus exclude individual providers unable to compete in the areas of price, products, services, and geographic coverage.

Historically markets in a time of transition have offered great opportunities, and healthcare today is no exception. A close look at the major forces driving the market will reveal trends that are likely to become clear market cornerstones for the next generation of medical practice. This article reviews 10 major market forces working in single medical specialty groups, particularly in women's health, and suggests 10 business trends in which women's healthcare groups are likely to participate.

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Gone are the days of the OB-GYN physicians treating their female patients and considering it a good day's effort to have simply delivered high quality medical care to a trusting individual. Such a view ignores the underlying importance of the event, and fails to recognize the full significance of the relationship. To fully appreciate a newer, fuller view of this medical event is to begin to understand the overwhelming influence of women on the business of healthcare, including marketing, pricing, product development, and service delivery.

The New View of Women's Care

Break down the component pieces of the *old view* and the full potential of a *new view* begins to emerge.

On one side of the *old view* equation, the physician operates under a professional ethic demanding that he/she act in the best interest of the person seeking counsel and treatment. Such trust is implicit in the relationship; hence, the willingness to disclose to one's physician things not easily told to anyone else. The confidence built into the relationship is foundational, and inseparable from the experience of the healing art.

On the other side of the *old view* equation is the female patient. Consider the following highlights about women:

- They are the decision-makers for approximately 75% of America's healthcare dollars.
- They spend from $.70 - $.80 of every drug dollar.
- They represent 60% of all physician visits.
- They are more likely than the husband to choose a health plan."(A)
- They make 70% - 90% of all health care decisions for themselves and their families.
- After age 14 they visit a doctor 25% more frequently than men.
- They are hospitalized 15% more frequently than men.
- Women consume 60% of all health care services.
- They represent 60% of all Medicare participants and 75% of nursing home residents.
- Women-only operations account for 11 of the top 20 most frequently performed surgeries.
- Pregnancy and maternity care are the largest expense

categories in most health plans, representing over 20% of total costs.

- More than 13% of women's health care expenditures go to OB-GYN physicians.
- Women's health accounts for four of 10 quality and access measures and six of 11 utilization measures for health plans reporting to the National Committee for Quality Assurance."(B)

Women are the clearly dominant force on the consumer side of healthcare. Put the two components of the *old* equation together and the *new view* of the women's care medical specialty cries out for acceptance: Physicians are medical professionals in a relationship of implicit trust with exceptionally powerful individuals who influence not only their own healthcare patterns but also those of children and spouses.

Women's care is the hub of healthcare in general, and consequently, considerable attention is being given to the management and growth of this medical specialty. Today approximately 40 physician practice management companies (PPMC) are publicly traded, and roughly 40 similar organizations are waiting for their opportunity to move into the public market. (C) "Of those 40 companies which are waiting, nearly two-thirds are single specialty PPMCs", many of which are oriented toward women. (C) Extant provider groups, including hospital systems and health plans, are likewise focussed on the bellwether that is women's care. What is the attraction of this single specialty, and what might the future hold?

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Single Specialty Provider Groups: The Case for Women's Care

In addition to the matter of consumer influence mentioned above, a second reason for the high interest in single specialty women's health provider groups is the relative ease with which market dominance is created in that specialty. Compared to the number of primary care physicians in a given market, there are relatively fewer physicians required to adequately cover the medical service area for a particular specialty. From that smaller number of specialists, fewer still are needed to exert significant market influence, a relatively easier task than trying to consolidate enough primary care physicians together to influence a market. This ease translates into faster growth for specialty medical management groups, and potentially lower capital requirements for that growth.

Another set of reasons for the high interest in single specialty women's health provider groups is financially based. Among them is the high potential for "same site" revenue growth. Wall Street's tolerance of PPMCs grew by acquiring physician practice revenue streams. But they showed lack-luster performance delivering promised increases in revenue at individual physician practices, and the tolerance may be wearing thin. Women's health offers the traditional physician practice management company a wide variety of opportunities for ancillary revenue streams, including nutritional information and products, imaging services, educational services, behavior modification, counseling services, birthing center development, menopause management, executive physicals, clinical trials, and many more. Consolidating OB-GYN physicians into groups and launching these additional programs can be a lucrative endeavor.

Another closely related financial reason for the high interest in women's care provider consolidation is the potential to achieve economies of scale in developing some of the services mentioned above. (C) Pooling patient volumes to underwrite these new programs and services helps justify start-up costs and long term capital costs for infrastructure and systems. Influencing this aspect of development are the current Stark I and the proposed Stark II regulations on physician group ownership of ancillary healthcare endeavors. Becoming a large group can, in many cases, not only provide an economy of scale, but also can make it easier for a group of physicians to own internally a related service. This makes it possible to broaden the spectrum of care, lower overall patient costs, and improve quality by managing the continuum of care.

Another financial reason for the attractiveness of women's care provider groups is the higher physician incomes, and in many cases, the higher margins typically present in specialty medical practices compared to primary care practices of the same patient volume. (C) In managed care, particularly in capitated care, the

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operating margin, and therefore the ability to create retained earnings, is very important in maintaining the financial viability of the practice. For businesses seeking growth capital, as many PPMCs are, higher margins are a strong feature in being more successful in attracting investors; hence, in part, the attractiveness of single specialty provider medical groups, especially in women's care.

One more point to be made on the financial attractiveness of single specialty providers, and in particular women's care, is the growing evidence that gatekeeper models of managed care are not cost effective. (C) To the contrary, it appears that health systems eventually duplicate services with a gatekeeper approach. Not only does this model just delay the eventual appearance of many patients at the specialist's office, but also the patients often arrive after more serious complications have begun to manifest. Getting a patient to the correct specialist in a more timely manner may well work not only in the interest of better quality care, but more cost-effective care.

Several reasons for the attractiveness of single specialty provider groups have to do with contracting, including the relative ease with which specialists can be capitated. (C) One of the most popular current trends in capitated contracting is the use of case rates or procedure rates. Their use varies somewhat with different provider groups, but generally they represent an attempt to assign a fixed price to a procedure or case for which the provider agrees to do all that is required for that case or procedure. The more discrete the case or procedure, the easier it is to price, because the number of possible outcomes is reduced. Obviously, within single specialty provider groups, cases and procedures tend to be more discrete, and women's care is no exception. And in discussing contracting options, it is also important not to forget the earlier points in this article, such as the possibility of achieving economies of scale with aggregated groups of specialists. The ability to manage pricing through volume is a very real part of today's healthcare delivery scenery.

Another attractive feature of single specialty provider groups is the improved coverage of sub-specialties resulting from the economies of scale in the specialty group's operation. (C) Very often in health plan provider panels the coverage for sub-specialists is marginal, and sub-specialty providers can struggle in terms of financial gain due to the low volume of procedures. The health plan, too, can struggle because of the potential for sub-standard care from those not performing many of the procedures on a routine basis. Working to cover sub-specialty care by incorporating it within the boundaries of the specialty practice, such as in women's care, provides an opportunity to improve quality through the use of internal quality improvement measures enacted by the specialists. It may also make it easier to find more willing providers in spite of lower reimbursement rates for sub-specialty care because of the volume of cases generated by the funneling effect of having a group of specialists referring their patients centrally.

A related contracting possibility that comes with single-specialty provider groups is the potential to develop legitimate "centers of excellence" in a particular area of care. (C) This applies not just to sub-specialties, as mentioned earlier, but to the specialty itself. Because of the higher volume of cases, and the ability to

share costs of expensive equipment, specialty care groups can improve the quality of care while keeping costs down. In matters relating to anti-trust in healthcare, provider groups can be challenged as being too large in a given medical service area. The ability to show quality remaining constant or improving while the price of care remains constant or drops is a real plus in defending the size of the group.

Finally, physicians have indicated that the single specialty provider group is attractive to them because they are working among like-minded individuals. (C) In multi-disciplinary provider groups, there can be competition for patients, such as between women's care physicians and primary care physicians. For example, is a woman who comes to her OB-GYN physician for her annual physical seeing a specialist or her primary care provider? Is an annual Pap smear, which can be done either by primary care physicians or by OB-GYN physicians, more appropriately done by one or the other? Aside from the "competition" for patients, there may also be a lack of focus in multi-disciplinary groups, and as a result, greater difficulty in making decisions of a strategic and operational nature.

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Women's Care: Directions and Opportunities

Clearly, providers of care to women are in a position of great influence in the healthcare marketplace. Consequently, healthcare systems, other provider groups, health plans and related payers are intent on having some say in the development of this area. Because of the forces mentioned above, there are several directions in which single specialty medical care, and in particular women's care, might go. Consider these possible trends.

Single specialty providers will need to grow in order to achieve the influence they seek, and antitrust considerations will be a continuing and ever-present issue as they do. Popular legal opinion in antitrust matters suggests that groups representing approximately 33-40 percent of the providers in a particular specialty in a given medical service area may be near the limit of their individual size without raising the specter of antitrust violations. Even in a community with a total provider base of 150 women's care specialists, that means only 50-60 physicians in the group. Unless that group of 50-60 physicians treats an overwhelming majority of the female patients in that service area, they may be vulnerable to exclusion from provider panels and replacement by other physicians unless the patients are willing to boycott the health plan that excludes their physicians. The net effect of this issue is that individual group size, while important to maximize within antitrust guidelines, may be second in importance to the size of the patient population represented by those physicians.

Another dimension of growth that is likely to emerge is the networking of women's care groups across several medical service areas. This is a reasonable development in light of the antitrust restrictions within a given market. By redefining the medical service area for a medical group to a larger geographical territory, planners are able to "count" other providers when calculating the percentage of providers within a group, thereby reducing the percentage of providers belonging to the group. Beyond antitrust matters, physicians need to be able to negotiate with statewide, or even national health plans that are not limited to local availability. The larger the territory for the health plan, the easier it is to build the case for an extended network of linked providers.

The values of the linkage are clear. First, if negotiations are underway with a statewide payer, it can be highly advantageous to speak with the voice of several groups of providers across that broader territory. A second, and somewhat more subtle reason, is that HMO licenses are subject to numerous constraints, including a provision that if a certain percentage of their provider panel withdraws during a contract period, it could place the license in jeopardy. Simply put, gaining size from affiliation is an attractive negotiating posture.

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So as health plans reach out across several market areas, and recruit physicians into their provider networks, the relative size of even a large local single specialty network could be greatly diminished. If single specialty networks are to have any hope of negotiating their contracts from strength, they must keep pace with and match the territory of the payers with which they deal. This becomes particularly important as single specialty networks of different specialties consider joining together in physician organizations for greater negotiating clout, which is the third trend to be considered here.

Look for single specialty networks, including women's care, to seek and build alliances with other single specialty providers. An example of this might be the alignment of primary care, pediatric and women's care groups. Another example of such a linkage might include cardiologists, anesthesiologists, and cardiovascular surgeons. These kinds of alliances represent opportunities not only to speak with the economic clout of a large business enterprise, but also in a way that invites creative contracting where the interests of the patient cross these specialty areas. Protocols that reflect quality of care measures for a spectrum of care developed across multiple specialties can be more attractive to payers seeking to build quality of care indicators into their contracts than those of single specialties.

While these alliances evidence a common thread of the "continuum of care for patients," some women's care groups are looking simply to build economic and contracting leverage by the company they keep. Consider, for example, providers who represent what is known as referral or indirect revenue. A survey of the healthier system will suggest that the collective revenues of cardiology, OB-GYN, radiology, and orthopedics represent more that 50 percent of the revenues of medical specialties. Although a patient care continuum is not always easy to trace across these particular specialties, their voice together, by virtue of their economic strength, is significant. Some women's care physicians will be opting first for this kind of economic negotiating strength in their contracting alliances with payers, and secondarily arranging for patient referral patterns that enhance the quality of the care being delivered.

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Increasingly, women's care groups will seek to diversify by bringing related, but historically non OB-GYN care services into the women's care practice. The principal reason for this is the ability to contract for a broader continuum of care from payers and thereby offset declining revenues from traditional patient care. Examples of this include gynecologic oncology, adolescent care, nutrition counseling, executive women's physicals, specialized infertility services, and massage therapy.

A related trend will show that some women's care practices will seek to diversify from strictly a service organization into one with sales of products for women, and possibly for others. Examples of this include nutritional supplements, specialized pharmaceutical products, innovative products for women's care, and specially assembled literature for the interests of women. The progressive women's care groups will likely seek to be the first in the market to offer these products, and may attempt to lock up exclusivity marketing relationships with manufacturers for their medical service area.

Another area of diversification into which women's care groups are moving is the conduct of clinical trials. Historically this was a very lucrative area for physicians, since it often involved not only compensation for the trial itself, but also the provision of staff from the vendor to help with the office activities, ostensibly in the interest of quality control. It is still an effective way to offset declining revenues from direct patient care today. However, another dimension of the clinical trial arena is the marketing value of being able to differentiate one women's care group from another. The marketing goal would be that the medical group capable of sustaining clinical trials of a new drug or product would be perceived as the group capable of maintaining quality of care issues at very high standards. In addition, the group would begin to build an image of having access to the latest and most improved version of whatever product or service is available for women, since they are on the "cutting edge" of clinical trial activity.

A trend in the area of contracting will involve the women's care groups seeking to differentiate themselves by providing higher quality of care more cost effectively than their competitors. Historically, and to a very large degree still today in less mature managed care markets, contracting is done first on the issue of cost. If providers are first willing to provide the care at the discounted rates, then they get to have the second conversation, which is on the matter of geographic coverage. If the panel of physicians can do the care for the "right" low price, and if the network is large and dispersed enough to cover the population, then the physicians may indeed have an opportunity to contract for the care. With single women's care groups the path is similar in that negotiations often center on a group's ability to offer a lower price than a competitor.

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But increasingly the single specialty physicians have to compete with other single specialty groups for the opportunity to contract with a payer. In some cases both groups are equally cost-effective and geographically dispersed. This has yielded a new ground for competition in the area of quality. Most physicians, and healthcare administrators, will admit that quality is particularly hard to define, and in the absence of clear parameters the industry is falling back on measures that are easily quantifiable, such as C-section rates or numbers of inpatient days. Physicians are quick to point our that a high C-section rate does not necessarily mean that the care was unnecessary or medically inappropriate; it may mean that the physician was treating a population with a higher acuity or more difficult circumstances. Nevertheless, as more payers pay closer attention to such performance statistics, physicians will be further encouraged to join larger groups. Higher than expected performance rates, however justified, would be averaged into a larger physician pool of rates, some higher and some lower, and therefore more likely viewed statistically as within established norms.

Higher quality of care is measured in other ways than arbitrarily selected, albeit easy to measure rates like C-section rates. Another issue for payers is the consistency of the care being provided. In a large group the variation in care methods can be significant, and the attendant costs can be as varied. In recent years protocols for care have become a popular way for physicians to standardize their treatments. A group of physicians agrees upon an approach to treat a particular situation, and refines this pathway to identify the most cost-effective approach to a successful treatment experience that does not compromise quality of care. Payers sometimes even work with physicians to offer suggestions on how they can work together to implement a protocol-driven system of care. The value to payers is the ability to gather data on compliance with the protocols by the physicians, called "profiling," and from this analysis the ability to identify somewhat more clearly which physicians are acting in the interest of quality and cost as defined by the protocols.

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The development of healthcare protocols, and the associated development of the high powered information systems to managed that data and create the physician compliance profiles, leads logically to the next trend of women's care groups, which is to take risk contracts. A risk contract, in simple terms, is a contract in which the physicians and payor contract to share the risk of being able to deliver the care to a population for the mutually agreed upon budget. Sometimes that risk takes the form of sharing in the leftover funds at the end of the budget year on some predetermined distribution between payor and physician. In another approach the physician group might simply take over the entire budget for their specialty and seek to deliver all of the appropriate care for the budget year in a way that creates cash reserves for the physicians.

In either case, protocols, the ability to profile physicians and the capability of managing the flows of funds are necessary for physicians to be able to price their services and products. Pricing is the essential foundation for risk contracting, and provides physicians the comfort level that what they are undertaking is financially viable. Look for physicians and payers to enter into more contracts where they agree to work together to take the risk for meeting the budget for healthcare costs in a given contract year.

Lastly, a trend in women's care groups will be for them to take on more public accountability for the influence they represent. Women's care groups, by virtue of their relationship with decision-makers in healthcare, will be held to higher and more community-based standards for their contribution to the greater good of the medical service area. While the requirement for high quality medical care will continue, an additional standard of community goodwill will be a natural extension of the women's care medical group. Public forums for education, helpful information, referral mechanisms for non-women's care, sponsorship of community health fairs and similar events, will all become natural extensions of the women's care group which sees itself as simply rising to the higher calling of the new model for women's care.

One additional note on these trends is that they will be happening sooner rather than later. Increasingly the healthcare market is a frenzy of physician group aggregation. Economies of scale for purchasing and the sharing of large capital costs, such as information systems, make the mergers and acquisitions of medical care groups a common occurrence.

As buyers and sellers of medical care practices wrestle with the challenge of establishing a price for the practice, physicians are becoming more aware of the importance of the revenue from these ancillary services, products, protocols, and the ability to take risk contracts in enhancing the value of the practices. For all

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