

PHYSICIAN PRACTICE OPTIONS™

April 30, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Long-term Contracts Pose a Dilemma for Physicians Seeking to Exit PPMC Deals

The recent downturn in the physician practice management industry has forced some publicly traded PPMCs into bankruptcy; others to sell off practices; and some to slow down or halt new acquisitions. This decline in the fortunes of PPMCs also is affecting physicians, prompting many to take a serious second look at the management agreements they have with PPMCs—agreements they once thought would last for years.

Scattered among the rank-and-file of the 10% of all U.S. private-sector physicians affiliated with public PPMCs—either directly or through an IPA—are lessons about what is to be expected as physicians seek to get out of their agreements with PPMCs, some of which extended for as long as 40 years.

“Initially, doctors thought these PPMCs would do rare and wondrous things; be a knight in shining armor, so to speak,” says Robert Bohlmann, a consultant in Arlington, Texas, with the Medical Group Management Association in Englewood, Colo. “And the PPMCs certainly assisted the groups in terms of consolidation, growth, contracts, and new revenue streams, although they probably didn’t fulfill the expectations the physicians had for them. But then, the doctors perhaps read more into these deals than they should have.”

Such unrealistic expectations are understandable, given the fact that the PPMC industry had nearly quadrupled in just four years. In 1994, about a dozen publicly traded PPMCs dotted the landscape; today there are about 30 publicly traded PPMCs, including dental management companies,

and about 150 privately owned PPMCs, representing about 40,000 of the nation’s 535,000 practicing physicians, according to the AMA.

Physicians and their attorneys are drawing on whatever works to help extricate the physicians from deals they say are failing to deliver the financial and managerial rewards the doctors had counted on when they sold their practices for lucrative prices in a seller’s market. Attorneys are hard pressed to find loopholes in the PPMC agreements with physicians, but they have been trying to use as yet untested state and federal regulations that call into question certain PPMC arrangements regarding what regulators call kickbacks and fee-splitting.

“I wasn’t involved in putting the deals together, and frankly I’m glad I wasn’t because there wasn’t a lot of thought as to the unwinding of those deals,” says attorney Abigail Watts-Fitzgerald, a specialist in acquisitions, mergers, and partnerships for Steel Hector & Davis, a Miami law firm. “Many of the deals were done fairly quickly in order to take the companies to the IPO market.”

With PPMCs often owning the fixed assets, such as furniture and equipment, and leasing them back to the physicians, or holding a security interest in the accounts receivable, severing ties can be a complex process. “They’re like divorces,” says Watts-Fitzgerald. “Innumerable unwind issues are involved.”

Often, the buyback provisions in the contracts cementing these deals were designed to kick in only under a few narrowly defined

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Physicians Should Prepare for Episodes of Care

Physicians are likely to be paid a global fee for episodes of care in the near future, experts say. Based on the success of demonstration projects by the federal Health Care Financing Administration (HCFA), Oxford Health Plans, and Anthem Health Plans, HCFA will begin to use global fees for episodes of care, and the reimbursement system is likely to spread to other payers as well, according to Douglas Emery, president of Zoadigm Health Systems Inc., consultants in Salt Lake City. Emery is the author of *Global Fees for Episodes of Care: New Approaches to Healthcare Financing* (McGraw-Hill, 1999).

Mark Wynn, a senior analyst at HCFA, says HCFA may introduce global fees for all or almost all Medicare diagnosis-related groups (DRGs). Payment will be administered through physician hospital organizations (PHOs) for inpatient and outpatient care. Discounts by physicians and hospitals will be in the 3% to 5% range and discounts will be phased in over three years.

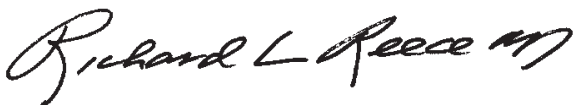
By definition, an episode of care is a definable disease event or procedure, such as a colon resection for colon cancer. Medicare administrators think of episodes of care as being similar to DRGs. Peter R. Kongstvedt, MD, a member of our editorial Advisory Board, explains that using episodes of care requires a linking of all the health care resources used in a defined event.

A global fee would include all payments for all components of care, including diagnostic studies, therapeutic services, consultations, outpatient and inpatient visits, hospital costs, and physician fees. To arrive at a global fee, health care purchasers would total all of these costs and discount the hospital costs and the physician fees by 3% to 5%.

This form of payment will grow quickly because HCFA will mandate global fees for 95% of hospital DRGs within three years, Emery says. HCFA might proceed sooner, but the agency is currently spending much of its time and energy seeking to ensure that its systems will be running on Jan. 1, 2000.

Global fees for episodes of care are preferable to other reimbursement systems for several reasons. For one, they put physicians in charge of medical care, as they should be. A plus for patients is that they receive only one bill. In fact, where global fees and episodes of care have been used, patients have expressed high satisfaction. Other benefits are that costs are controlled, and the economic incentives for physicians and hospitals are aligned without the need to create an enormously expensive and invariably complex integrated delivery system.

What's more, once the Medicare system—the country's largest health care purchaser—moves toward global fees and episodes of care, other payers will follow.



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Global Fees for DRG 104
 (Coronary artery bypass graft
 with cardiac catheterization)

	Medicare	HMO
Hospital	\$30,639.00	\$18,328.00
Heart surgeon	3,581.14	5,371.71
Anesthesiology	764.72	1,147.08
Cardiology	1,240.38	1,860.57
Radiology	177.94	266.91
Total global fee	36,403.18	26,974.27

Note: All fees are discounted by 3% to 5%.
 Source: *Global Fees for Episodes of Care: New Approaches to Healthcare Financing* (McGraw-Hill, 1999).

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Inventor Seeks to Improve Efficiency

Why is it that?" So begins a typical observation by Jerry Spitz, MD, father, physician, inventor, entrepreneur. This time what's irritating Spitz is the fact that most HMOs won't give him their provider lists so he can include them in one of 145 versions of his pocket-sized physician phone directory, *The Little Blue Book*.

While being a bit touchy—"easily frustrated" is how he likes to think of himself—certainly doesn't make him unique among physicians, Spitz is unusual because his complaints often lead him to find solutions.

These quests for solutions have led Spitz to create things both small, like sticky notes that can become a permanent part of a patient's record, a product for which he holds the U.S. patent; and large, such as the company that in 1988 started the phone directory and now includes an online electrocardiogram registry called EKGonline, and QUIKMD, physician office software. All three are part of the company that produces *The Little Blue Book*. Spitz is also poised to sign a contract with a large Internet search engine that would use his physician database.

And those are just the projects Spitz has time for today; a handful of other ideas that he hopes will also enhance physicians' efficiency and improve care is waiting to take shape. Among his suggestions for other physicians: make more use of e-mail and the Internet.

Spitz's company, newly christened the National Physicians DataSource of Avon, Conn., has a workforce of 40 and gross revenue last year totaled more than \$5 million. Spitz still practices as a primary care physician under contract to six HMOs, and it's the practice of medicine that gives rise to his ideas. A group of residents at Hartford Hospital once dubbed him "The Edison of Medicine," a label they had emblazoned on a T-shirt for him.

"I'm always thinking of new things," says Spitz, 53. "I am trying to meet the needs of doctors. It's my way of improving health care. I am the lab, so to speak. I look at myself as the creative director of National Physicians DataSource. I think, 'What do I need, and what don't I need.'"

Spitz's wife, Lauren Engel, is the day-to-day force behind National Physicians DataSource. It was Engel who suggested selling extra copies of the directory, and she also was the motivator behind the second big product from National Physicians DataSource: EKGonline.

Have EKG, Will Travel

EKGonline is another invention spurred by Spitz's personal experience. An elderly family friend at his mother's 80th birthday party went to the hospital with symptoms possi-

McCormack, director of Hartford's public health department, would like all city residents at high risk for heart disease—some 27% of the population, according to a recent study—to have an EKG and be able to store it through a service such as EKGonline. "This sounds like a great tool to me," she says. "I'm still investigating how we, as a public health department, might be able to promote something like this."

"There is truly a great need for this, and as word gets out about it, I can see it taking off," adds Bryan Ghiloni, MD, a family

A group of residents at Hartford Hospital once dubbed him "The Edison of Medicine."

bly caused by a heart attack. While waiting in the ER because the friend's EKG showed some nonspecific changes, Spitz and others discussed how helpful it would have been if a baseline EKG had been available. Engel suggested that their firm could be such a depository, and the two launched EKGonline. The service has been available since November, and in February there were almost 1,000 EKGs being stored.

For now, there is no charge for EKG storage, a practice Spitz will continue if he can obtain sponsors, such as those that support *The Little Blue Book*. In addition to storing EKGs for other physicians, Spitz is making the storage service available directly to consumers at a cost of \$19.95 for two years.

Because it is critical to maintain confidentiality of patient records, personal identifiers—such as a pass code and date and city of birth—are used instead of a patient's name. Spitz also has patients answer a few simple questions that provide information helpful in an emergency, such as whether they are on medication of any kind, are hypertensive or diabetic, have any allergies to medication, and have a living will. Any physician can call the service and request that an EKG be faxed or sent by e-mail, virtually anywhere. (The address on the World Wide Web is ekgonline.com.)

As with *The Little Blue Book*, EKGonline looks like a hit, say its enthusiasts. Katherine

practitioner in Cleveland, who has sent several dozen EKGs for patients to the online service. It is particularly useful for patients with abnormal electrocardiograms and those at high risk for cardiac problems. "It's an excellent service," Ghiloni says. "It takes very little time in the office and could be of great benefit in an emergency or just when patients are changing doctors."

For Spitz, that's the motivation behind all his innovations—bringing greater efficiencies to physician office practices, particularly for practitioners who aren't in a large medical group and must cope with increasingly time-consuming and often arbitrary rules and procedures.

"All these other patient software programs are very good," Spitz says. "But I think the industry is missing the point by getting involved in issues that are not relative to the physician's practice. The focus seems to be on connectivity, having your records in one central place, with systems built for large medical practices. I see the opposite as the goal. My main goal is to make my work more efficient and more accessible to myself and others. I want my records in my office, and if people want them, I will send them."

QUIKMD tracks formulary compliance, always an issue for physicians with more than one MCO contract. "Let's say there is a choice of six cholesterol medications, and

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Aetna only allows two. The software knows that this is an Aetna patient, so when I write a prescription it will tell me whether the medication is on Aetna's formulary. That way I don't get a call at 7 p.m. from the pharmacy saying, 'Aetna won't pay for this drug. Can you change it?'

Last fall, when he posted notice of the software on *The Little Blue Book* Web site, Spitz got requests from 400 to 500 physicians for the software over the first several months. But since EKGonline has commanded so much of his time and resources, he has not had time to launch QUIKMD as he would like, and he has told these physicians to wait while he searches for a sponsor.

Using E-mail

For his own practice, Spitz is a firm believer in e-mail communication with his patients, even though only 15% have e-mail. A sign in his office lists Spitz's e-mail address and suggests that for nonurgent medical matters, patients should communicate with Spitz via e-mail. Spitz has patients e-mail him when they've had lab work done that he has requested; he then checks results and sends them back a message via e-mail. He also uses e-mail to stay in close contact with patients who need such care, like David Wampold, a diabetes patient, who has been in Spitz's care for 10 years.

"He will spend time with you when you go to his office, but there is always the next patient waiting. With e-mail, there seems to be time for me," Wampold says.

"His blood sugar is perfect," Spitz says of Wampold. "I don't think I could have done it without e-mail."

Taking e-mail a step further, Spitz also advocates that physicians, particularly those with primary care practices, establish their own Web sites. By answering a series of questions posed on the Web page—for example, Do you have a productive cough? Is the mucous green?—patients would know if an office visit is warranted. Spitz also is developing Web site templates for physicians to use for certain diseases that would help patients assess the severity of their symptoms.

The Limits of Innovation

Spitz knows his software, online services, and the like are not enough to keep

patients happy. To do that, he says that the human side of medicine—his own bedside manner and the attitudes of his office staff—is crucial to maintaining good patient relations.

"I don't work for the HMOs; I work for my patients," Spitz says. "What I find myself doing is handling the incidental types of illness quicker, and using the time I gain that way with patients who need more of my time." By triaging his time more appropriately, he believes he can make incremental improvements in patient care. To do so, he needs an experienced staff.

"My office staff has been with me for over 15 years, and I think keeping good staff is very important," Spitz says. "How do I keep them? By paying them what they deserve. I recognize that my practice is like a marriage between me and my office staff and my patients. It has to be worked at; there has to be mutual respect. I think that fact is frequently overlooked."

For all his inventiveness, a few aspects of his practice remain outside of Spitz's control. His life—and those of his patients—would be easier, particularly in a managed

care environment, if these problems were addressed, he believes. And for these kinds of issues, Spitz encourages his patients to advocate for change.

For example, standing referrals. As other physicians will surely agree, Spitz finds it a waste of time to write and rewrite referrals for a patient with a chronic illness, such as diabetes, to see a specialist. Though his software makes this process simpler, he still must do it each time. Some states have changed laws to require HMOs to permit patients with certain diagnoses to have a referral relationship already established, which the District of Columbia has recently done.

"The way to make change is through our patients," Spitz says. "So when an unnecessary restriction arises, I tell my patients, 'The reason I have to do this is because of your HMO.' This is no longer about reducing the cost of health care benefits," he says about the purported purpose of managed care. "This is about insurers making more money."

—Reported and written by Theresa Defino, in *Silver Spring, Md.*

One Problem Leads to Big Success

Jerry Spitz, MD, wrote the first version of *The Little Blue Book* because he was trying to solve a problem all physicians face: He ran out of time one day. Spitz—a family physician, entrepreneur, and father—realized he needed such a publication more than 10 years ago after he missed a family dinner because he was wasting time looking for a physician's phone number.

To prevent that problem from happening again, he asked a member of his office staff to compile a list of phone numbers for him. Believing that other physicians could use such a phone book, but suspecting that they probably wouldn't want to pay for it, Spitz hit on the idea of getting pharmaceutical sponsors to support *The Little Blue Book*. Today it comes shrink-wrapped with a leaflet of prescribing information about popular medications.

The directory is customized by metropolitan area and distributed to physicians by specialty. It is delivered free to 275,000 physicians who pay \$7.50 each for any additional copies. The success of *The Little Blue Book* surprises Spitz. "I never thought we'd be selling it," he says. "This year we sold over 100,000 copies." That's a lot, given that physicians can get one free. (The Web address is www.thelittlebluebook.com).

Much of the success of the directory is due to Spitz's steadfast commitment to what he calls "uncompromised" accuracy for a product that fills a void. He also publishes only information about how to contact physicians in their offices, not at home. All entries are faxed to every physician's office to be reviewed for accuracy, and follow-up calls are made if the fax isn't returned. This industry standard is the financial foundation for all Spitz's other endeavors. He believes the accuracy of the data is what gives his firm unparalleled access to the thousands of loyal physician users.

—TD

Some Doctors Struggle as PPMCs Falter

In 1993, Lewis Eastlick, MD, was a solo practitioner in Fort Lauderdale, Fla., when MedPartners Inc. came calling. Executives of what became the largest publicly traded U.S. physician practice management company (PPMC) told the 36-year-old hand surgeon they wanted to help him grow his practice.

"We can put a bunch of physicians together to reduce overhead and centralize functions. And, because we have business savvy, we can do a better job than you at managing your practice," Eastlick recalls the MedPartners representatives telling him.

He took the bait. "I felt this was where medicine was going and single practitioners were going to have difficulty surviving," he says.

Six years later, MedPartners physician groups are up for sale, including Eastlick's former nine-doctor group. Disillusioned by the entire experience, Eastlick financed his own return to solo practice several months ago. Would he allow a corporation to direct his practice again? "I'd have to be crazy," he says. "We were a ship at sea with no one at the helm. I believed MedPartners would do what it said it would do. I learned a valuable lesson: No one but me knows best how to run my practice."

Last year, at least 3,500 U.S. physicians fled or were forced to leave through bankruptcy or divestiture at least nine of the estimated 30 public PPMCs. It was the first time in a decade of meteoric growth that the fledgling PPMC industry had a bitter year. Once Wall Street sweethearts, the average share price declined 70 percent, according to Jondavid Klipp, editor of the biweekly newsletter, *Physician Practice Management Report*, in New Rochelle, N.Y.

Securities analysts, attorneys, and industry insiders now are divided over the future of PPMCs. Naysayers believe it is the end of a sector flimsily built on a house of cards. Others hold that what occurred last year is a major correction and that PPMCs were simply experiencing growing pains. Lessons will be learned, there will be a massive restructuring, and some PPMCs will remain to prosper, experts say.

"What we've seen is typical of any

nascent industry," says Monique Neal, an industry analyst with Merrill Lynch, in New York. "The PPMCs that are still standing haven't gotten nearly as much press as the bad ones. The good ones will revolutionize the industry."

Neal and others point to companies such as American Oncology Resources Inc., in Houston. AOR has taken patients away from hospitals to place all cancer diagnostic and treatment needs into outpatient care, a move that proves they can generate value and growth, she says. Concentra Managed Care Inc., in Boston, and the second largest

Inc., West Palm Beach, Fla.; Advanced Health Inc., Tarrytown, N.Y.; and Complete Management Inc., in New York City.

A few private PPMCs among the estimated 150 closed their doors for good. The most notable was Doctors Health Inc., of Owings Mills, Md. DHI once represented 400 physicians through IPAs or owned practice agreements. It filed for bankruptcy under Chapter 11 in November.

Meanwhile, lawsuits are flying back and forth between physicians and their PPMCs. In some cases, doctors trying to break their contracts with PPMCs claim they should

"I learned a valuable lesson: No one but me knows best how to run my practice."

—Lewis Eastlick, MD

public PPMC, PhyCor Inc., may remain because each one is managed by skilled executives, experts say.

"Many of the companies sprang up in the 1990s from thin air with no operating histories and little management experience," says Klipp. "The industry grew too quickly and that's why it ran into problems. Companies like PhyCor with longer track records and good management should survive."

But some have already written the PPMC epitaph. "PPMCs have been a dismal failure," says Jeffrey Cohen, a board-certified health care attorney with Strawn, Monaghan & Cohen PA, in Delray Beach, Fla. "Overhead increased, they didn't improve contracting, and physician management services were nonexistent."

Among the failures: the third largest PPMC, FPA Medical Management, once of San Diego, now of Miami, filed for bankruptcy under Chapter 11 in July. FPA was followed to bankruptcy court by PHP Healthcare of Reston, Va.; BMJ of Boca Raton, Fla.; Integrated Medical Resources, of Lenexa, Kan.; and Medical Asset Management, of Laguna Hills, Calif.

MedPartners announced in November its plan to divest its PPMC business. Others that cut their ties to PPMCs include: PhyMatrix

not pay management fees because promises were not kept. In return, PPMCs say withholding those fees is forcing them into receivership.

In the numbers of downed and injured companies are the lives of physicians and their legions of patients set adrift. "It's emotional for me," says George Makol, MD, 50, an allergist at Thomas-Davis Clinic in Tucson, Ariz. "I've been here at the clinic for 15 years and it's been trashed in two years by greedy, corporate people interested only in enriching themselves." The large, multispecialty Thomas-Davis was shuttered last year when owner FPA went under. Makol returned to private practice.

Physicians such as Makol and Eastlick who move back to solo practice often have to buy back their hard assets, such as equipment and exam tables, or start anew. Also, they must hire staff, buy malpractice and health insurance policies, and sign leases or mortgages.

The process of starting up again is so onerous that many physicians end up choosing hospital ownership or another PPMC. Trouble is, some hospitals are also divesting physician practices, as some staff-model HMOs have in past years, and more PPMCs could end up discontinuing opera-

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tions. "I wouldn't be surprised if a handful or more PPMCs exit the industry in 1999 and beyond," says William McKeever, a senior vice president for health care services for PaineWebber, in New York.

By switching partners doctors may simply be swapping one set of problems for another. "I've seen doctors who jump from one practice manager to another and lose something with every jump," says Robert Bohlmann, a consultant in Arlington, Texas, for the Medical Group Management Association, in Englewood, Colo. "They could be making their situations worse."

Still, solo practice is not an option for many new physicians saddled with large debts for education. About half of all graduated medical students carry mean education debt levels higher than \$75,000, according to the most recent survey published in September in JAMA.

For Peter Lechman, MD, a pediatrician in Chicago, private practice was not a consideration. Since Lechman, 36, had amassed \$105,000 in education loans when

he finished his residency last year, he needed to be employed somewhere. He chose the Glen Ellyn Clinic near Chicago, a multispecialty group of 160 physicians. The group's owner, MedPartners, has put the practice up for sale.

"Even if I could have financed a solo

staff, a full patient load, and mentors."

Undoubtedly, physicians need what PPMCs offer: someone to do the billing and hire staff so they can focus on patient care. Oddly, venture capitalists are still doling out cash in support of private PPMCs, according to PricewaterhouseCoopers, CPAs and

"With absolute certainty, I know our group will be sold. Is it viable in the long term? It's hard to say."

—Peter Lechman, MD

practice, it didn't make sense," Lechman says. "I would have gotten crushed. I didn't want to learn how to operate a business at the same time I was learning how to be a good doctor. That would have been setting myself up for a lot of risk. The buzz on the street when I was looking for a job was that it was going to get tougher financially even being in a small group. Here, I walked into an established practice with equipment,

health care consultants. In their worst year ever, 1998, private PPMCs received \$227 million in the first three quarters, compared with \$314 million in 1997 and \$211 million in 1996. Moreover, David Menkhaus, a health care attorney in Boca Raton, Fla., reports he knows more physician groups looking for PPMCs than he has PPMCs willing to take them on.

But now that the three largest models of employment—staff-model HMOs, hospital ownership, and PPMCs—have proven flawed and unstable, how do physicians know which way to go? With the divestitures and bankruptcies, what was once a contradiction in terms: "unemployed physician" has become a reality.

New doctors are skeptical about the future. "With absolute certainty, I know our group will be sold," Lechman says. "Is it viable in the long term? It's hard to say."

The reality is, no consolidation method tried to date has been foolproof. "Although there is a need for physician management services and theoretically the models make great sense, the models we've seen are not grounded in the realities of physician behavior," says attorney Cohen. "As a practical matter, physicians are unique and rigidly independent. Unlike the consolidations in the oil and banking industries, I see the dominant surviving form in this industry as being a mass return to solo or small-group practice. That's what works best. It's inefficient, but physicians are happier."

Adds PaineWebber's McKeever: "I don't have a lot of confidence that PPMCs will be able to change their stripes to position themselves for long-term viability."

Others think some PPMCs have staying

Advice to Consider Regarding Practice Management Contracts

Attorneys, securities analysts, and experts in the physician practice management industry make the following suggestions to physicians considering a contract to affiliate with a PPMC:

- Interview physicians already associated with the PPMC that you may be interested in. Determine whether they are satisfied and if they find value in the affiliation. Ask a lot of questions. First and foremost, find out about the corporate culture and decide if you would fit in. Determine if the focus is on quality clinical care, growth, or maintaining the status quo. Choose groups and markets carefully to make sure philosophies are aligned.
- Don't rush into a PPMC deal, experts say. Look at every employer as you would view a potential spouse.
- If you are considering the sale of a solo or group practice to a PPMC for stock and cash, be aware that the value of that stock can become worthless, as it did for at least five companies that folded in 1998.
- Look into the PPMC's track record. Get the company's financial records, both the annual report and 10K. Talk to the auditor or accounting firm that audits the books of the company. If it's a private company, check the cash flow and balance sheet. Use professionals, such as attorneys, financial advisers, or accountants, to help guide you. The money you spend before you sign may be a pittance compared with the money these professionals save you.
- Hire professionals to check out the PPMC's management. What were these managers doing before? How did their previous company perform?

—MG

power because they will reinvent themselves. "Some of the public companies will survive and do well. They will reach into inpatient care, outpatient clinics, and clinical trials," says Sandy Lutz, an industry analyst at PricewaterhouseCooper, and author and editor of four books on the business of managing hospitals and doctors. Her most recent book is *Practice Management at the Crossroads* (McGraw-Hill, 1999).

PPMC executives, too, remain bullish. "While some individual corporations are dampening the perception of the industry, you shouldn't throw out the baby with the bath water," claims Ronald Pierce, chief executive officer for Integrated Orthopaedics Inc., a publicly traded PPMC in Houston. "All PPMCs can't be placed into one basket. It's not whether the PPMC industry is viable, but whether the company you are talking with is viable."

Experts believe that in the future PPMCs will not own practice assets but will work more as consultants to physicians, offering a menu of services, such as bookkeeping or managed care negotiations. In other words, PPMCs will take on a different form.

For now, the recent turn of events for PPMCs and the negative press about it have forced physicians who once eagerly sought to affiliate with a PPMC to examine those contracts more cautiously. "The process of acquiring physician groups has become more lengthy. The deals are taking longer to close

one model will work for everyone."

Those who predict the future generally eat crystal ball dust, says attorney Cohen. Nonetheless, he foresees medical fees being squeezed even more, forcing doctors to alter their behavior by forming larger groups for economies of scale, working longer hours,

"It's not whether the PPMC industry is viable, but whether the company you are talking with is viable."

—Ronald Pierce, Integrated Orthopaedics Inc.

because physicians are asking more questions and getting more lawyers, accountants, and consultants involved. They've become much more savvy about the negotiating process," explains Klipp.

Lutz suggests that doctors choose carefully among practices focused on managed care or fee for service, single hospital versus multiple hospital, single specialty versus multispecialty, and other forms. What's more, she says that "a doctor can't take the advice of the colleague down the street because no

joining unions, starting or working with provider-sponsored organizations, and myriad other unpredictable, unthinkable arrangements, he says.

In the midst of a rapidly changing job market, there is only one certainty, says PaineWebber's McKeever: "I forecast continued difficult times ahead. There's more pain in store for physicians and there's no anesthesia that can ease that pain."

—Reported and written by Maureen Glabman, in Miami.

Restrictive Covenants May Limit a Physician's Options

One issue to address in severing a relationship with a physician practice management company is any noncompete clause, or restrictive covenant, that may be part of the contract. If there is one, the right of a physician to practice in the same geographic areas where he or she has built a practice may be limited.

Consider the case of the Holt-Krock Clinic, in Fort Smith, Ark., in which a number of physicians in the clinic are suing to sever ties with PhyCor Inc. a large PPMC in Nashville, Tenn. The case shows just how difficult enforcing restrictive covenants can be.

After balking at a clinic plan in 1996 that he said would have cut into his \$1.4 million annual income, ophthalmologist Gary Bodiford, MD, was subsequently terminated by Holt-Krock. As a result, Bodiford set up his practice across town, and then filed a legal challenge against PhyCor and the clinic, claiming that a

noncompete clause would prevent him from practicing medicine in Fort Smith.

In his orders, the Arkansas state judge hearing the case ruled that in the absence of unusual circumstances, state law rendered such a restrictive covenant unenforceable. "The public has a vested interest in access to a physician of its choice," the judge wrote. "A covenant not to compete constitutes and is an unreasonable restraint of trade and violates public policy of the State of Arkansas."

Bodiford's lawyer, Sam Sexton, of Sexton & Fields, in Fort Smith, says, "The first and most important lesson from this case is that if you terminate an employee without cause, you can't enforce a covenant not to compete." The 30-mile noncompete zone, intended to apply to both current and prospective PhyCor locations, would have encompassed much of the entire state, Sexton says.

Since 38 other Holt-Krock physicians

have sued in an effort to be released from their contracts with PhyCor, and about two dozen have left to join a new non-profit practice formed by a nearby medical center, the Bodiford ruling may mean none will be hampered by their noncompete provisions. The clinic employs more than 100 specialties and 46 primary care physicians.

PhyCor is appealing the judge's ruling, and is involved in a separate case regarding terms of its management agreement with Bodiford. It is also pursuing its position that the nearby medical center, in wooing away some of Holt-Krock's physicians, is guilty of tortious interference. In the latter case, the Arkansas trial judge has appointed a mediator. In January, PhyCor agreed to sell the Holt-Krock Clinic to Sparks Regional Medical Center, in Fort Smith.

—Reported and written by David Adlerstein, in Fort Lauderdale, Fla.

(Continued from page 1)

events of termination, which means that today they must be either negotiated from scratch or left to the courts to decide, explains W.L. Douglas Townsend Jr., managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care.

Physician groups that sever ties with their PPMCs stand to do well financially, at least in terms of how much money the doctors need in order to part company, says Watts-Fitzgerald. When they initially sold their practices, the physicians got a windfall upfront from companies that were looking at an income stream over 20 or more years, not four years, she says. "Everybody was bidding for a fairly discrete group of doctors, and if they tried to come up with a reasonable offer, they would have lost out," she

been unsuccessful. Often, when the PPMC is losing money and wants to get out of the relationship, it will simply ask the physicians to buy back accounts receivable, divide other assets amicably, and end the relationship, the experts say.

But fiduciary responsibility to shareholders may hinder a PPMC from making a settlement that is too generous, says Michael Blau, an attorney with McDermott Will and Emery in Boston. "By pressing too hard, physicians can actually make the situation worse for themselves because a PPMC can't give more value than it has," he says. "On the other hand, PPMCs are always looking out for their reputations, and they don't want to be perceived as beating up on doctors."

Sandy Lutz, an industry analyst with PricewaterhouseCoopers, in Dallas, says

better off cutting their losses and seeking other arrangements" with hospitals, health systems, group practices, or even other PPMCs, he says.

Courtroom Confrontations

A good-faith approach toward the unwinding can prevent an acrimonious environment from pervading the medical practice. "It's often a tense situation, and trying to terminate early often brings a period of ambiguity during which everyone knows they'll not be working together," says Peter Grant, head of the legal department of Davis Wright Tremaine, a law firm in San Francisco. "I've seen some fairly amicable partings and even in those contexts, I've seen some unpleasant situations. Doctors are independent, and when word gets out to other doctors that things aren't going well, they tend to lose respect for instruction from physician practice managers."

Richard C. Holdren, president and CEO of RH+ Medical Group Inc., a brokerage firm in Houston, that handles appraisals and sales of medical practices, says, "What is actually happening is that a lot of doctors are just whimsically throwing up their hands and walking away from contracts, saying, in effect, 'So sue us.' The companies have no choice but to sue because the companies went to the public for the money to invest in them. Now, because of the defections, these companies are all but worthless, and a lot of shareholder lawsuits are occurring as a result."

Since courts wield so much power in these matters, Holdren advises putting boardroom negotiations before courtroom confrontations. "The doctors are better off negotiating a deal rather than having a trustee, out of their control, negotiate it for them," he says. "If they are unhappy with their current arrangement, they shouldn't wait until someone makes the decision for them. Now is the time to buy back the practice because many PPMCs are selling for their asset value."

When negotiations prove fruitless, physicians unhappy with their PPMCs have little choice but to challenge their management contracts on one or both of two legal fronts: either the PPMC is in breach of the contract because of its failure to live up to management obligations, or the contract is

"Initially, doctors thought these PPMCs would do rare and wondrous things; be a knight in shining armor, so to speak."

—Robert Bohlmann, Medical Group Management Association

explains. "There are companies out there that overpaid dramatically and they're now paying once again, so to speak."

Confidentiality clauses prevent parties from revealing the specifics of buyback settlements, but with PPMCs no longer proffering hefty upfront multiples of a practice's annual revenue, and with their stocks trading at lower levels, the market value of their practices has dropped to less extravagant levels, thus lowering the cost of the buyback.

A Bargaining Boon

For physicians, this situation may represent a bargaining boon in dealing with PPMCs looking to unload less profitable practices or to exit a market entirely, some experts say. Often, these PPMCs are hampered by the unenviable scenario of being responsible for all costs from dissatisfied medical groups, a situation that may provide some leverage to physicians seeking to work out buyout details.

In fact, physicians are in a position to exact favorable conditions if a PPMC is seeking to divest itself of an unprofitable group or to leave a market in which it has

that regardless of a physician group's individual circumstances, it is still just one of many other groups that may be seeking to extricate itself from a PPMC. "This isn't happening in a vacuum," Lutz says. "The PPMC will have to take some sort of write-down, and if the write-down is too big, the PPMC will have to answer to shareholders and other creditors. The question is, can the PPMC justify that write-off based on market factors? It comes down to more than working out an amicable deal between the physicians and the company; other onlookers and interested parties are also involved."

A nonthreatening approach to severing relationships with PPMCs is advisable, says Jeff Peters, a physician consultant in Harvey, Ill., and president of Health Directions Inc. In other words, physicians should go through the proper organizational channels by meeting with the on-site practice director or manager, for example. Peters is a vigorous advocate for physicians seeking to leave problematic PPMC affiliations. "Physicians with an entrepreneurial bent and a need for autonomy are probably

Attorneys are drawing on whatever works to help extricate the physicians from deals they say are failing to deliver the financial and managerial rewards the doctors had counted on.

unenforceable because it contains clauses in violation of existing laws or regulations.

In October 1997, the Florida Board of Medicine issued a declaratory statement known as the Bakarania decision in which it opined that management fees paid to PPMCs based on a percentage of a practice's revenue violated state laws prohibiting fee-splitting. Six months later, the Office of the Inspector General for the federal Department of Health and Human Services issued an advisory opinion, not considered legally binding, that marketing and billing fees paid to PPMCs on a similar percentage basis may violate the federal anti-kickback law.

The Bakarania declaratory statement is limited to the Sunshine State and has been stayed as part of an ongoing dispute between Phymatrix, a company in Tampa that until last year had managed physician practices as a PPMC, and the Access Medical Group, a physician group in Tampa. Magan Bakarania, MD, was one of 14 of the 15 physicians affiliated with Access Medical Group who challenged the legality of paying marketing and billing fees as a percentage of net annual income under the group's agreement with Phymatrix. The case is pending in a state appeals court in Florida. Until a decision is reached in that and similar cases, attorneys in a number of states continue to look for ways to have contracts declared unenforceable under existing state and federal laws.

"There is going to be a wave of litigation on the legality of these contracts," says Watts-Fitzgerald. "And to the extent that physicians believe they can reach economic agreement with a company, there's going to be more litigation. It's very much up in the air as to what the courts will do. Are they going to overturn all of these agreements?"

Most attorneys don't believe courts are likely to overturn these agreements, and many say issues of enforceability should not be used as a tool to cloud the more important matter of whether a company is keeping its promises. "Lawyers claim that the con-

tract was fraudulently induced or misrepresented," says Blau. "Some claim that contracts are void and unenforceable based on anti-kickback theories. The point I want to stress is that every PPMC contract should have a clause that physicians will not challenge the enforceability of the agreement.

"It's one thing to sue a PPMC for not living up to its obligation, but it's another thing to say a contract is unenforceable," Blau continues. "That's shabby commercial behavior. How would doctors feel if they have a great

tainty that comes with leaving may not be offset by a new relationship with a hospital or a PPMC. Without exception, advisers counsel prudence and reasonable expectations as physicians weigh whether the PPMC market's tumult is temporary or long-lasting.

"As I scour the physician world, I find groups that have substantive capital needs, poor management, and no real governance," says Townsend. "So there is still a market demand for organizations that doctors can partner with, and which allow

"By pressing too hard, physicians can actually make the situation worse for themselves because a PPMC can't give more value than it has."

—Michael Blau, McDermott Will and Emery

deal with a PPMC and the PPMC walks away? It's a double-edged sword."

Restrictive Covenants

Noncompete clauses, also known as restrictive covenants, must be addressed if physicians intend to practice in the same geographic areas where they have built their current practices after severing their relationship with the PPMC.

"Courts in states where there's a restrictive covenant will enforce the covenant as long as it is reasonable in nature, in geographic scope, and in duration, and the court will determine the circumstances," explains Blau. "Generally, the courts will enforce only where there is adequate consideration paid for the noncompete clause, and where the effective geographic scope is consistent with the PPMC's area of competition, not just places the company is planning to enter."

While exiting a PPMC arrangement is likely to solve some problems, doing so can easily be the source of other difficulties. The cost of leaving the PPMC and the uncer-

physician groups to have a seat at the table."

The structure of future deals, however, is likely to incorporate lessons learned from the current wave of unwinding deals, including less lengthy contract terms, "prenuptial" buyout provisions, more physician control over such things as staffing levels and managed care contracts, and more careful consideration of what's being paid for and what isn't, Townsend says. For example, is the PPMC paying to be involved with managing all aspects of a practice or just certain limited aspects of management?

So, the plummeting stock prices—having fallen from their heights a year ago—don't necessarily spell the disintegration of an entire fledgling industry, say analysts. "As the industry tries to rebound, PPMCs will have to come back with shorter contracts, provisions that will define terms for parting, and less purchase price paid upfront, with value coming from improving productivity," says Townsend.

—Reported and written by David Adlerstein, in Fort Lauderdale, Fla.

Medical Center Aims to Show That It Can Be Competitive Even Under Managed Care



Ralph Snyderman, MD, is chancellor for health affairs, executive dean of the Duke University School of Medicine, and president and CEO of the Duke University Health System in Durham,

N.C., a large academic health care complex with an annual budget of \$1.7 billion. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q: I'd like to begin our discussion by talking about the academic medical center of the 21st century. As chancellor, president, and CEO of such a center, you have the task of guiding this giant system in the new and threatening environment of managed care. How do you view your role in this effort, and where do you see Duke's system headed?

A: My duties are to represent a broad spectrum of health issues, including education, discovery research, clinical research, health care, and the development of an integrated community health system. It is extremely important that all of these areas be represented appropriately and integrated so that the individual components of the system derive value from the others. I see myself as an integrator, a facilitator, and, at times, an innovator, working with others to implement a shared vision of what an academic health system ought to be. We see Duke's solution to reinventing health care and academic medicine as a work in progress. In our health system, our goal is to be the provider patients want because of our commitment to providing high-quality, community-oriented care. Having a continuum of care allows us to be proactive in developing health plans that meet the specific needs of individuals, rather than applying the cookie-cutter approaches of managed care.

We believe it's more rational to deliver

health care by finding the most cost-effective way to deal with every individual in the system. We need to be able to integrate health care across a continuum of care to achieve cost savings and marketing clout that enhance the value of the Duke University Health System in the market. One of our strengths is that we are a physician-led organization, and we understand the value and importance of physician-patient relationships. What's more, being a nonprofit entity means that we can invest more in the future and that we can derive the tremendous benefit of all the intellectual properties that are created within the medical center.

Q: In 1992, Duke decided its mission would focus on creating societal value from its core missions of medical education, research, and clinical care. Do you regard that decision as a turning point for redefining Duke as a medical center?

A: Absolutely. It was an important point in our history because it signaled that we were committed to changing as an institution. Based on our read-

enterprises are under Duke's umbrella.

A: Within the school of medicine, we have a faculty practice called the Private Diagnostic Clinic, which has about 850 physicians, 41 of whom are community physicians who have joined the faculty. We also have approximately 800 residents in graduate medical education. We own a group called Duke University Affiliated Physicians, which consists of 59 primary care physicians and 16 physician assistants. Recently, we assumed a 20-year lease for Durham Regional Hospital, and we have purchased and operate Raleigh Community Hospital in Wake County, one of the fastest growing areas in the country.

We also have a wholly owned home infusion company; a 50-50 joint venture with St. Joseph of the Pines for an entity called Duke & St. Joseph Home Care; and Triangle Hospice, which became part of our system last year. We are also affiliated with an IPA called PrimaHealth, which has about 1,150 physicians throughout the Research Triangle area. In

"Having a continuum of care allows us to be proactive in developing health plans that meet the specific needs of individuals, rather than applying the cookie-cutter approaches of managed care."

ing of the opportunities as well as the dangers we faced, we realized that although we were an institution that had great intellectual value, we would also have to demonstrate that what we were doing had material value to the health of communities if we were to survive in an increasingly competitive marketplace.

Q: Describe for us the Duke University Health System; that is, how many physicians are employed; how many hospitals are in the system; and what other health care

addition, United Methodist Retirement Home is interested in joining our health system, which would give us skilled nursing facilities throughout much of our service area. Finally, we have a 50-50 ownership of a managed care company called WellPath but are likely to become sole owners in the near future.

Q: As I understand it, your strategy focuses sharply on being a regional center rather than being a national company, is that correct?

A. While we are an international institution, you are basically correct. Roughly 80% of the patients whom we treat come from a fairly defined geographic area: central North Carolina, southern Virginia, and northern South Carolina. Most of our emerging health system is focused here, but we have other approaches as well. Our centers of clinical excellence have the ability to transfer unique benefits for patient care to other regions in which such needs exist. For example, we are discussing with Naples Community Hospital the joint development of a center of excellence for cancer care in Naples, Fla. In this case, there is a need and an excellent local partner that has asked us to help out. We've had similar conversations in other areas of the Southeast. As we go beyond our service region, we look for partnerships in which we come in at the request of good health care providers that would benefit from our expertise. We prefer this approach to going in uninvited to compete.

Q. *The acquisition of physician practices by some academic health systems has been a disaster because of cultural gaps, loss of productivity, and so on. How does Duke handle its relationship with its acquired physicians?*

A. Our goal in outright acquisition of physician practices is limited and is not part of our long-term strategy. The reason we purchased 59 practices when we did was because of the need to move quickly from being a specialty-based practice to a practice capable of delivering managed care to a large population of Duke University employees, which amounted to about 33,000 people. When the university decided to go to a managed care type of plan in 1993, the fastest way for us to be able to deliver it was to purchase practices in the areas in which our employees live. Since then, we have not purchased more practices. As for the practices we purchased, many of them belonged to individuals we know quite

well, and we did everything we could to make them feel a part of our family. The quality, manageable number, and their geographic distribution helped us to be successful in integrating those practices

Institutes of Health has begun to pay off in terms of major discoveries that will have practical application for the practice of medicine. That's obvious in what's going on in the pharmaceutical

"The health care system needs to be better organized across the continuum of care and to function in an integrated manner focusing on the individual."

into our health system. In general, I think that purchasing large numbers of physicians' practices engenders great potential liability.

Q. *Have outside ventures changed the culture of Duke's faculty? Have you encountered much internal resistance?*

A. There is no question that the culture of the faculty has changed. But I think it would have changed no matter what because of increasingly difficult managed care contracts, decreased reimbursement, and having to work harder for the same or less pay. Such factors prevent physicians from taking for granted that they have guaranteed safety by being part of an academic medical center. After all, we face real-world issues, which have, at times, sent chills through every academic medical center in the country, including our own. Outside relationships always engender discussions among our faculty as to whether those relationships will benefit the center or take resources away from it. There are always exceptions, but members of the faculty at Duke have been understanding and supportive of what we've been doing because they understand that it is key to the success of our medical center.

Q. *In terms of research, what new directions is Duke taking?*

A. We believe that the federal investment in the National

and biotech industries, which are replete with exciting opportunities. This being the case, we have made a very large investment in clinical research and have assembled what is now the largest academic clinical research organization, called the Duke Clinical Research Institute. It focuses on large multicenter trials, whether they are NIH or industry-driven trials, and conducts complicated, often multi-institutional, studies. It also amasses a large clinical database that will help in the era of evidence-based medicine.

Another area in which we are preparing to make a major investment is genomics sciences. Within the next five years, the human genome will be mapped and probably sequenced, and we will begin to get much more information about genetic diseases and about complex genetic disorders. The opportunities for genomics to change the practice of medicine are a certainty, and to prepare for these opportunities, we will increase the size of our faculty and enhance our research facilities to accommodate a big effort in this area. The entire health system will benefit from this initiative. Another area we are focusing on is brain imaging and analysis in an effort to understand the function and the nature of the human brain. Genomics and studies of the brain are the two areas likely to have major discoveries in the next

(Continued on page 12)

(Continued from page 11)

decade. And we're investing in them as well as in basic biomedical research.

Q. *Where will all the money come from for research, the training of new doctors, and caring for the uninsured?*

A. That is not an easy question to answer, and I won't be glib in trying to do so. Expense reduction and rational development of resources are key. Disorganization in health care delivery

improve health and lower costs. We need the help of government to ensure that we are on a level playing field and that all those who benefit pay their fair share.

Q. *How do you come to grips with the costs of weak programs are subsidized by the profits of strong programs, where surgeons support pediatricians, and so on? In other words, how do you create an environment in*

stems from the fact that surgeons and radiation oncologists, who tend to be better paid than primary care doctors, have some responsibility for primary care practice because they would not be able to function unless primary care is successful. Developing an understanding of the fact that, as a multidisciplinary practice plan, we have to support the component parts is a process that we're going through now.

Q. *You set aside part of each year to care for patients. Has this clinical presence helped you keep in touch with what your physician colleagues are thinking and to see the world better from the patient's point of view?*

A. I'd like to think so. When I'm in the hospital seeing patients, the one who's helped the most is me. Being a practicing physician grounds me in what health care is all about. It lets me know the power of the physician-patient relationship and the tremendous gratification physicians can and should gain from dealing with people. That means a great deal to me, and I wouldn't be able or willing to do all the other things I do unless I considered myself to be a physician. My having a clinical presence is helpful for the health system, too, in that as an attending physician on a busy unit I get to see what works and what doesn't.

I try to be careful about not harping too much on the things that don't work so that people won't dread my presence. Having a clinical presence gives me a much better view of what the physicians

"When I'm in the hospital seeing patients, the one who's helped the most is me. Being a practicing physician grounds me in what health care is all about."

engenders waste and lost opportunities. Our nation's health care system needs to position itself so that it is both rational in dealing with people's needs and aligned so that it does so in the most cost-effective way. What's more, the health care system needs to be better organized across the continuum of care and to function in an integrated manner focusing on the individual. The development of standards of care or health enhancement systems that decrease the cost of health care in the most efficient way for every given individual is key.

Since the federal government is the single largest health care payer through Medicare and Medicaid, it will have to continue providing a reasonable and fair amount of funds for the health care of the people we serve. One of the largest distorting factors in the health care system today involves health care for the uninsured who indeed receive care. I won't say it's adequate care, but they do receive it. And usually they receive it in the emergency rooms of academic medical centers, and it is paid for by shifting costs to other entities, which is becoming increasingly more difficult to do. We have, in a sense, ignored this issue because it's politically too difficult to tackle the needs of the uninsured. But, as a country, we have to address it. In short, we believe regional integrated health systems, such as ours, can develop more effective ways to

which every tub sits on its own bottom?

A. We have come from an era in which every department was a tub on its own bottom, and in the days of plenty the system creaked along and in some areas worked well. But in the late 1980s and early 1990s, some of those tubs began to leak heavily, which led to an internal reassessment and an understanding that we can't be a series of independent tubs. There is great mutual interdependence within medical centers, and internal cross-subsidies need to be understood and made rational. We worked hard to disentangle our accounting systems so that we could truly understand the finances of education, research, clin-

"We see Duke's solution to reinventing health care and academic medicine as a work in progress."

ical care, and each department within the system.

We are developing a culture in which the surgeons understand that their ability to have a practice and get referrals depends on primary care practices and that there needs to be mutual support across profit and loss centers to allow us to be a holistic health delivery system. Some of the greatest faculty disquiet

experience when they practice. What's more, I know that when I'm there, sometimes late in the evening, with other doctors, nurses, and staff, we develop a greater camaraderie. They understand that I'm one of them and not just another suit, which is what they call administrators. And I would hate to be thought of as just another suit.

—Edited by Paula D. Grant, in Lincoln, Va.

Sluggish Acquisition Pace Continues

By W.L. Douglas Townsend Jr. and Jill S. Frew

The market for physician practice acquisitions continues to be sluggish after the first two months of the year. During the 12 months ending Feb. 28, 144 physician practice transactions were announced, compared with 176 in the same period a year earlier, an 18% decline. Some of these acquisitions are physician groups that were acquired by a physician practice management company (PPMC), an HMO, or a hospital that are now being resold to other buyers.

Among the notable acquisitions this year was one involving ProMedCo Management Co., a multispecialty PPMC in Fort Worth, Texas. On Jan 12, ProMedCo agreed to affiliate with Prism Medical Group, a 12-physician multispecialty group in Boca Raton, Fla. Most other multispecialty PPMCs, including PhyCor Inc. in Nashville, have cut back sharply on physician acquisitions and others have ended their acquisition programs. Several of these PPMCs also have announced that they are exiting the physician practice management business.

On Jan. 27, MedPartners announced that it will sell its Team Health division, which provides billing and payroll services to radiologists and emergency room physicians at 385 hospitals in 31 states. MedPartners is selling Team Health to a group of private investors for \$335 million, including Madison Dearborn Partners, Cornerstone Equity Investors LLC, Beecken Petty & Co., and Team Health's management. MedPartners will retain a 7.3% ownership in Team Health. This sale is part of MedPartners' strategy to exit the physician practice management business.

On Feb. 16, Christus Primary CareNet of Texas, an affiliate of Christus Santa Rosa Health Care, in San Antonio, announced that it will assume operations of six health centers in San Antonio that had been owned by Humana Inc., the

large managed care organization in Louisville, Ky. The agreement includes 20 physicians serving 28,000 Humana health plan members in San Antonio. The par-

when shares of Pediatrix had plunged. Pediatrix had been one of the last PPMCs whose stock price had remained steady despite the turbulence in the PPMC mar-

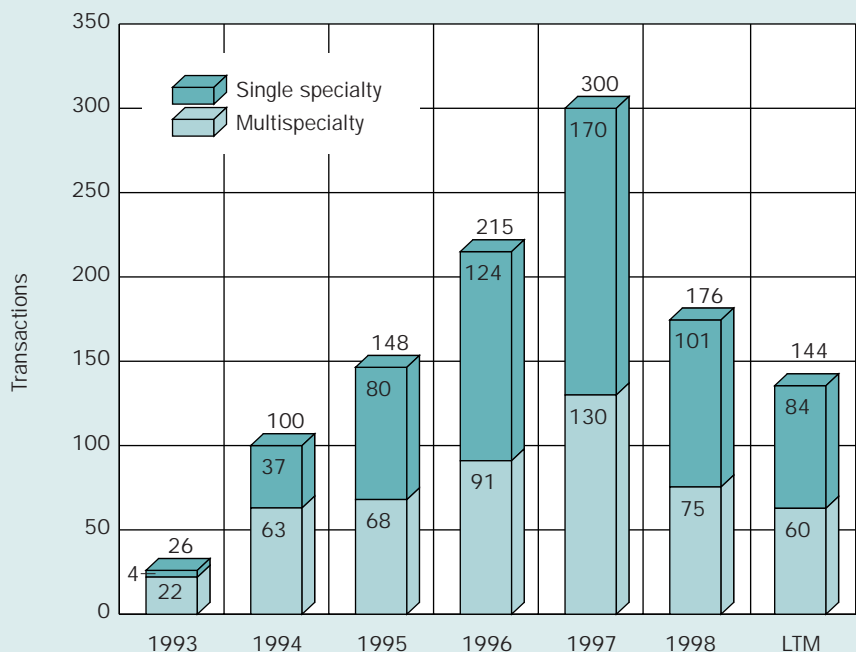
During the 12 months ending Feb. 28, 144 physician practice transactions were announced, compared with 176 in the same period a year earlier, an 18% decline.

ent company, Christus Health, is one of the nation's 20 largest health care systems.

On Feb. 25, Pediatrix, a PPMC in Fort Lauderdale, Fla., acquired Southwest Washington Perinatal Service, a practice in Tacoma, Wash. The acquisition came despite a setback earlier in the month

ket. Earlier in February, however, the company announced that it would restate its earnings for 1998 and its shares plunged 48% to \$28 on the news. Upon announcing the acquisition of Southwest Washington Perinatal Service, shares of Pediatrix rose 27% to \$31. ■

Number of Announced Physician Practice Acquisitions



LTM is last 12 months as of Feb. 28, 1999.
Source: Townsend Frew & Co., Durham, N.C.

W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care transactions. Also, he is a member of the editorial Advisory Board of Physician Practice Options. Jill S. Frew is managing director of Townsend Frew & Co.

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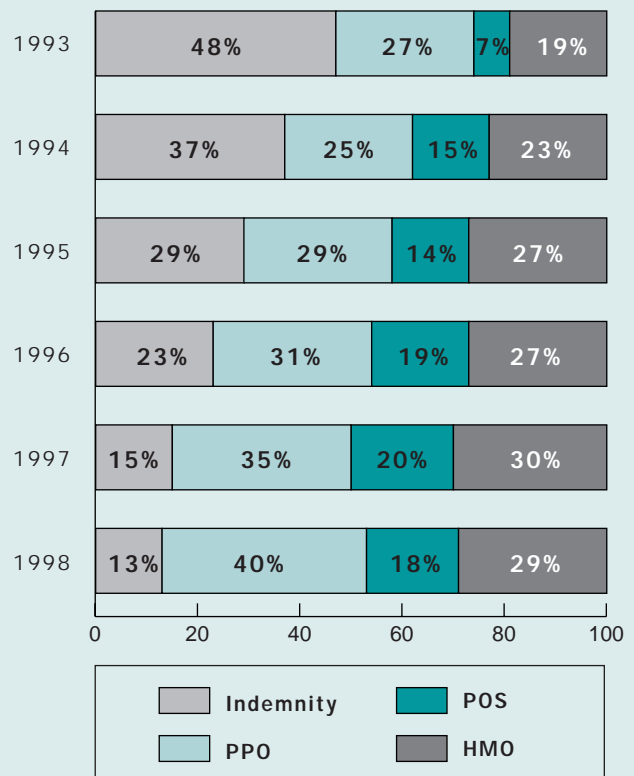
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HEALTH CARE TRENDS

Costs Rise, HMO Enrollment Drops

Health care costs rose sharply last year, and enrollment in HMOs dropped slightly, according to a report by William M. Mercer Inc., benefits consultants in New York. Costs rose by 6.1%, the largest annual increase since 1993. Physicians are not expected to see any improvement in income from such health care premium increases for at least another year because HMOs need the money to cover rising costs, experts say.

National Employee Enrollment Percentage of all covered employees



Source: William M. Mercer Inc., New York, 1999.

While costs are rising for all types of health plans, enrollment in the most restrictive form of managed care—HMOs—declined last year. Some observers believed HMOs and point-of-service (POS) plans, which let patients choose in-network or out-of-network care, would become the dominant form of health plans because they cost less than other health plans. Yet, physician provider organizations (PPOs) have become the most popular form of health plan even though they are more expensive than HMOs and POS plans. Consumer demand for greater access and improved ease of use has driven the popularity of PPOs, experts say. ■

Orthopedists Consider Merger Pros, Cons

Question: I am an orthopedic surgeon in a midsize southeastern city, and a member of a two-person group thinking of merging with a three-person group. Managed care plans recently came to our area, and they now have a 30% market share. What are the pitfalls of mergers? How is one accomplished? And should we consider forming a single-specialty orthopedic network as an alternative?

Answer: "Let me start by saying that a group of five orthopedic surgeons in a midsize city would likely be too small to be a real economic force in terms of managed care and to bid on contracts," says Bernard A. Rineberg, MD, an orthopedic surgeon and physician consultant with BAR Health Strategies, in New Brunswick, N.J. A member of the editorial Advisory Board of *Physician Practice Options*, Rineberg is an expert in managed care. "Expanding to a five-person practice is a step in the right direction, but the partners have to start thinking in terms of providing a full array of orthopedic services and making the merged group a significant market and convenience factor."

One of the biggest pitfalls with mergers, says Rineberg, is their great tendency to fail, or to "de-merge," as he calls it. "Often, physicians in two or more practices will formulate a merger, only to begin questioning later why they wanted to do it in the first place," says Rineberg. Mergers fail for three key reasons, he says. The first is that the professionals who are part of the merger lack a common culture. They often don't have the same ideas, work ethic, or financial situation. When they realize this failing, they feel as if they have gotten into the wrong "family." The second reason mergers fail is lack of a common vision. "Many physicians don't give

sufficient thought to why they want to participate in a merger until the transaction is complete," says Rineberg. "Then, suddenly, they realize that they don't quite know how they got to that point."

The third key reason mergers fail relates to the economics of practice. Rineberg urges caution when it comes to assumptions that a merger will result in substantial savings or increased income. "The duplication of services that most physicians assume will exist when two or more practices come together usually just isn't there," he says. "After a merger is complete, nobody wants to eliminate staff or cut back on services." The same is true of unspoken expectations related to income. "It's important for the partners—who may

The first step, he says, is to appoint one physician to be the leader of the new operation. "Somebody has to be the titular head, the benevolent dictator, if you will, who will make the decisions," says Rineberg. "This person should be compensated for administrative time on the same basis as a physician who is in the operating room or treating a difficult case. Otherwise, he or she will be more interested in spending time on patient care than on getting and keeping contracts, making sure that patients are well served, and doing all of the other things necessary for a practice to function under managed care."

The next step, Rineberg says, is facilitating the merger. To do so, physicians

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hardly know each other—to understand what a merger will do to their individual incomes," says Rineberg. "If someone's income is going to take a hit, that person should be told up front and the reasons why. Unhappy partners do not make for a successful 'marriage.' If any of the physicians discover that they can make more money outside the practice, don't be surprised when members start to drop out."

Administrator Wanted

These reservations notwithstanding, Rineberg remains convinced that a merger is a good solution for many practices, especially when the number of professionals can grow sensibly to cover a full array of orthopedic services, a significant geographic area, and support ancillary initiatives such as surgicenters, physical therapy, and imaging centers. He advises following the model used by many physician practice management companies.

must first consider the pitfalls discussed above. "It's also a good idea to bring in a neutral third party to act as a consultant or mediator," Rineberg says. "Investing in a knowledgeable consultant is money well spent and will reap rewards in that the merger is likely to last much longer by focusing on tough issues prior to the merger rather than leaving them to chance." Rineberg advises against seeking out a lawyer or an accountant who does not specialize in health care transactions. "The business decisions involved in a merger should be placed in the hands of someone who knows about medical practice," he says.

For physicians considering a merger, it's also important to have the practice undergo a SWOT analysis, Rineberg says. "SWOT stands for strengths, weaknesses, opportunities, and threats. Everybody in the newly merged practice has to know what the combined group's strengths and

Editor's note: Readers of *Physician Practice Options* are invited to call our toll-free line to speak with Richard L. Reece, MD, editor-in-chief. Often, Reece poses questions from readers to members of the newsletter's editorial Advisory Board.

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QUESTIONS FROM READERS

“A knowledgeable consultant will focus on tough issues prior to the merger rather than leaving them to chance.”

—Bernard A. Rineberg, MD, BAR Health Strategies

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weaknesses are, what the opportunities for improvement are, and how and when the union will thrust them into a leadership position in their community,” he says. “The threats can be internal or external: discontented members of the group who attempt to destroy the merger, for example, or practices outside of the merged group that adopt the same strategic plan and implement it better.”

An orthopedic practice may want to consider working toward the formation of a group that is large enough to cover a significant geographic area and to be highly diversified in the musculoskeletal area. “Managed care companies may consider an orthopedic office a priority practice if it is equipped to take care of every person who comes in with a musculoskeletal complaint and it covers a large geographic territory,” Rineberg says. “The keys are significant geographic penetration, convenient office hours, and flexibility in accommodating emergency cases.” While mergers are uncommon among orthopedists, says Rineberg, a few such practices have merged successfully. The groups that were not so fortunate, he says, lacked a good infrastructure for controlling patient flow, ensuring the availability of physicians, and facilitating prompt and accurate bill processing. ■

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