

Physician Practice Management – A New Chapter

The Insights in Brief

- After failing dramatically in the late 1990s, Physician Practice Management companies (PPMs) are back. Physician groups' affiliation with PPMs is accelerating and hospitals are more active purchasers than ever before.
- After two decades of healthcare industry evolution, PPMs have a much stronger value proposition. They are better positioned than traditional physician offices to make capital investments, manage risk, contract with payers, acquire patients, increase administrative efficiency, and achieve other economies of scale – i.e., to meet the substantially increased demands of physician groups.
- Success for PPMs depends in large part on motivating physicians by forming and clearly communicating the group's value proposition, aligning incentives, ensuring effective governance, and providing support in the physicians' local context rather than applying national, cookie-cutter guidelines.
- The arrival of next generation PPMs will provide many opportunities across the healthcare value chain, and everyone from payers to private equity investors can position themselves to benefit.

Physician Practice Management companies (PPMs) are gaining attention again. In 2012, kidney-care giant DaVita bought HealthCare Partners; the combined company immediately started acquiring and partnering with other large practices. Also in 2012, private equity firm Audax Group acquired Advanced Dermatology & Cosmetic Surgery and Welsh, Carson, Anderson & Stowe formed U.S. Anesthesia Partners. Even more recently, private equity shop Clayton, Dubilier & Rice completed the IPO of Envision Healthcare (formerly Emergency Medical Services Corporation) in August 2013 – a firm they had taken private in 2011.

Developments such as these might send shivers through those who remember the physician practice management debacle from the 1990s. Back then, PPM companies such as Phycor and MedPartners evolved the traditional back-office services model into an industry roll up, building sprawling empires of medium to large multispecialty and single-specialty physician practices. With the success of the early entrants, many well-funded followers jumped in. In 1997 alone, public PPMs raised \$2bn to fund the acquisition spree. Any physician group of scale auctioned itself to the highest bidder. By the peak of the phenomenon, in 1998, Sherlock Company estimated there were 39 public and 125 private PPMs.

Then the bubble burst. Initiated by bankruptcy announcements from MedPartners and FPA Medical Management in July 1998, eight of the 10 largest publicly traded PPMs had declared bankruptcy by 2002. Many doctor groups bought back their

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practices at pennies on the dollar. So what happened? Fundamentally, the competition for a relatively limited pool of physician groups large enough to be interesting targets drove prices to unsustainable levels, often 50-100% above the underlying cash-flow value (see sidebar). The time to bubble burst was accelerated by rapid margin compression, a result of declining premium revenue caused by a particularly vicious downturn in the underwriting cycle combined with the PPMs' inability to bend their cost curves. To compound the problem, acquired groups grew rapidly disenchanted as PPMs' focus on new acquisitions left them low on the priority list. Their frustration only increased when deals founded on equity participation collapsed in value. Faulty fundamentals caused the whole movement to collapse in a heap (see Figure 1).

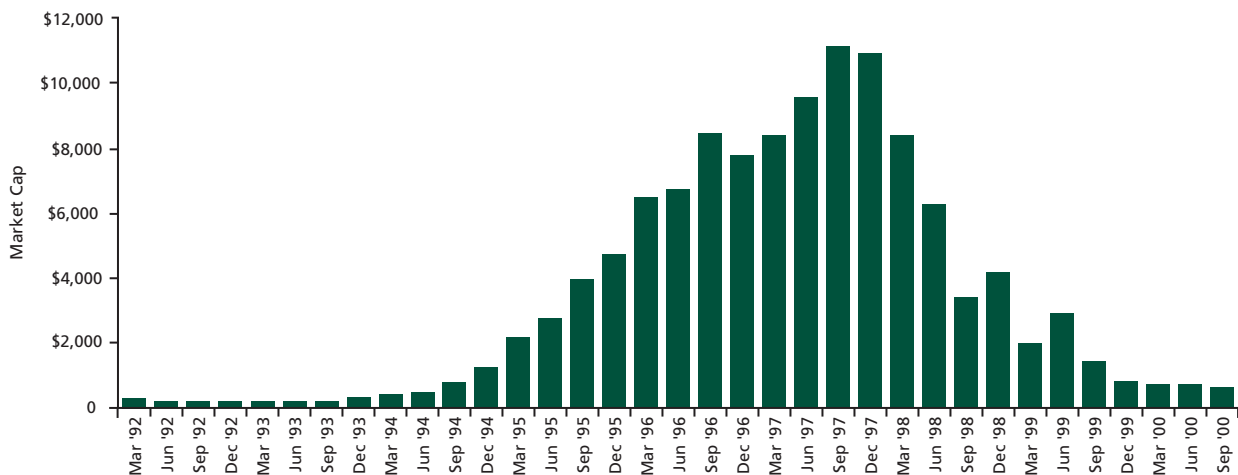
Almost 20 years later, we are witnessing a resurgence of PPMs. Physician groups are again favored targets of PPMs, and even more hospitals and health systems are on the hunt than two decades ago – either as part of their efforts to develop ACOs or because they are looking to protect their referral bases in the face of declining reimbursement.¹ Approximately 40% of physicians today are either hospital employees or employees of a practice owned by a hospital or health system.² To industry veterans, it looks like a bad remake of a bad movie.

Case Study

When Pacific Physician Services Inc. (PPSI), a long-term L.E.K. Consulting client, approached us in late 1994 to analyze their poor performance acquiring groups, the answer to their problem was price discipline. By refusing to pay above the fundamental cash-flow value of the business, PPSI was never competitive. Faced with the conundrum of paying value-destroying multiples to meet market growth expectations, they made the rational choice and sold to MedPartners in December 1995.

But physician practice management was an innovation that failed because it was premature and poorly executed, not unsound. Twenty years later, PPMs have a clear strategic rationale and value proposition. Indeed, the need is stronger than ever.

Figure 1
Combined Market Cap of Top 20 Publicly Traded PPMs



Source: Citi Research, Company Filings, Factset, Thomson

¹ For example, see Tip Kim's, "Hospital Economics and Healthcare Reform: No Free Lunch (In Fact, I Might Go Hungry)," L.E.K. Executive Insights, Volume XV, Issue 10

² Source: Jackson Healthcare

Physician group requirements have evolved substantially from back-office efficiency – which is still a primary need – to include capabilities such as advanced patient-acquisition methods, population-health and risk management and clinical effectiveness. These are all requirements that most physician groups, even those of some scale, are not capable of efficiently providing for themselves. The sequel to the PPM drama is likely to be more successful than the original – as long as PPMs adopt several key tactics to make PPM ventures succeed.

Why PPMs Make Sense

There are several fundamental gaps in the capabilities of traditional physician offices that PPMs fill (see Figure 2 for an example of PPMs' value proposition):

1. The ability to make capital investments. Today's clinical and back-office environments are increasingly becoming electronic, a transition that demands capital investment, sophisticated software, and process-management systems that are anathema to professional services organizations in general and doctor organizations in particular. In addition, effective management requires sophisticated data sharing across the value chain – independent physician practices simply do not have the wherewithal to manage data sharing well.

2. Population-health and risk management. Traditional fee-for-service arrangements incentivized physicians to maximize utilization. In the wake of healthcare reform, many specialties will see increases in bundled payments and other models that transfer the financial risk to the provider. To succeed, physician groups require the ability to negotiate sophisticated risk-sharing agreements with payers and the actuarial support to identify the patient populations and trends that drive medical-cost inflation. They also need to learn and share the care-model innovations that drive lower healthcare costs and increase quality.

3. Patient-acquisition sophistication. Patient decision making is changing due to increased patient financial responsibility for medical care and the increasing transparency of physician quality. At the same time, e-marketing platforms for patient

recruitment are rapidly evolving. This confluence of factors requires sophisticated, local patient-acquisition programs that are not in physicians' domain of expertise.

4. Administrative efficiency. When it comes to operational efficiency, the typical physician practice still has significant room for improvement. As a general rule, physicians want to practice medicine, not manage the back office or make decisions regarding revenue-cycle management, purchasing, and other tasks that are traditionally the purview of management executives.

Two decades later these needs have grown more acute. The number, complexity and capital intensity of electronic front-office and back-office systems have grown exponentially. The number and complexity of capitated risk contracts have expanded under the next wave of risk delegation. The administrative burden, regulatory requirements, patient billing, etc. has also increased.

Perhaps most importantly, physicians' attitudes about ownership and independence are changing. Whereas going into solo private practice was traditionally the dream pursued by most medical students, now most want jobs as salaried employees. In a recent poll of medical graduates, 75% of respondents said they preferred to work either in a group or hospital-affiliated practice.³ In large part, this evolution is a function of the exact complexities of practice management that a PPM is designed to address. PPMs can take the hassle out of practicing medicine. With the supply of larger group practices increasing, PPMs should see increasing demand for their services.

Complications

In the short term, accelerating hospital acquisition of physician groups could provide PPMs with real competition for group affiliation. However, we expect that, as hospital foundation employment contracts come up for renewal, the pendulum will swing in favor of physicians' independence from hospitals – as older physicians retire, productive, middle-aged physicians may feel trapped and be more inclined to return to physician-centric practices.

³ Source: Cejka Search

Figure 2
The PPM Value Proposition

Affiliate Support Services			
Corporate /Network Structure	Network expansion/ New clinic acquisition	<ul style="list-style-type: none"> Physician group target identification and transaction support Site location and architectural services Space and equipment planning and procurement 	<ul style="list-style-type: none"> Capital and coordination of/access to attractive financing for equipment/space build-out Reduced capital risk and liability
	Clinical	<ul style="list-style-type: none"> Clinical protocols and best-practice sharing 	
Practice Operations /Management Services	IT	<ul style="list-style-type: none"> Development or evaluation and selection of all required IT systems 	<ul style="list-style-type: none"> Revenue-cycle management EMR systems tailored to practice specialties Virtual practice/patient communications applications
	Reimbursement	<ul style="list-style-type: none"> Insurance contract review, analysis and (re)negotiation Coding analysis and fee schedule development 	<ul style="list-style-type: none"> Revenue-cycle management (claims, billing, collections)
	Commercial	<ul style="list-style-type: none"> Comprehensive, diagnostic marketing assessment Customized marketing, media, and promotion plan to attract more patients, increase referrals, and increase number of insurance payers 	<ul style="list-style-type: none"> Marketing-material development, including website design, development, search engine optimization Referral-network development and capture program Patient-financing programs
	Other operations/ management support	<ul style="list-style-type: none"> Operational performance improvement Work-flow analysis and scheduling Financial reporting and best-practices benchmarking 	<ul style="list-style-type: none"> Clinical, administrative, and financial performance measurement and reporting Guidelines for implementation of new strategies Operational turnaround for distressed practices
Human Resources Management	Compensation and benefits	<ul style="list-style-type: none"> Wage, salary and benefit methodologies and employee incentive plans 	<ul style="list-style-type: none"> Payroll processing
	Accounting and legal services	<ul style="list-style-type: none"> Federal, state and local certifications and licensures Compliance support and all necessary manuals, forms, policies and procedures 	<ul style="list-style-type: none"> Enhanced coverage and pricing for malpractice, health, life, and property & casualty insurance Cost containment and significant group-purchasing discount plans
	Recruitment, training, and employee management	<ul style="list-style-type: none"> Staff planning, recruiting, and hiring Employee position descriptions and manuals 	<ul style="list-style-type: none"> Human resources administration and ERISA expertise Clinical and administrative education and training programs

Source: Company websites, L.E.K. analysis

The second complicating factor is the participation of MCOs. United Healthcare recently acquired AppleCare Medical Management (49% stake); Memorial Healthcare IPA; WellMed Medical Management (80% stake); non-clinical management assets and personnel of Monarch HealthCare medical group; and Aveta Inc. In another example, Humana purchased Concentra and Metropolitan Health Networks and has publicly stated its intentions to continue to acquire providers. With the implementation of mandatory medical loss ratios, profit potential has shifted to the provider side and payers will continue to be aggressive bidders for multispecialty groups with strong Medicare share. How successful MCOs will be at extending acquired expertise to new markets remains to be seen. While the acquired groups have compelling capabilities, potential provider partners will need strong economic incentive to overcome their discomfort with payer partners.

Who Will Win

While conditions currently favor the growth of PPMs, tactics deployed by individual organizations will play a large role in determining which organizations succeed and which ones fail. From our work in and around the PPM space over the last two decades, L.E.K. Consulting has identified a number of best practices and detailed tactics for PPM success; the most important include:

1) “What have you done for me?” A strong physician-group value proposition (which is clearly and frequently communicated).

The foundation of a winning partnership depends on the physicians’ belief that they are far better off than they would be independently. Back-office administrative efficiency alone

is insufficient because the margin a PPM charges for services provided is often perceived to offset the benefits of scale and sophistication. To be robust, the value proposition needs to deliver superior income prospects and reduced hassle to physicians. Specific elements may include superior revenue generation, superior local marketing, payer contracting and per-patient revenue optimization, improved clinical efficiency from specialized front-office systems, processes and best practice sharing, as well as more traditional back-office efficiency. The nature of services delivered from the PPM also needs to be refreshed over time to meet the evolving needs of its network and to demonstrate ongoing value creation.

2) “Why should I care about business performance?” A physician business model that aligns incentives and motivates engagement.

It’s no secret that physicians are motivated by performance-based compensation. The challenge is to ensure physicians retain a strong link to the local practice while also ensuring their buy-in and participation in the larger entity (e.g., profit share). There are a myriad options that PPMs have tried over the years, but many of the more elegant models (e.g., tax-efficient equity participation) can create more friction than alignment (e.g., when equity values inevitably decline). Different models can work but general rules of simplicity and transparency should always be followed.

What the PPM Resurgence Means for Your Business

The arrival of the next generation of PPMs provides many opportunities across the healthcare value chain:

- **PPMs:** The challenge is to provide real value in an aligned framework, which is what ultimately derailed the 1990s generation. Optimizing physician alignment and incentives, developing real value in the clinical model, and achieving true back-office efficiency all present unique challenges, and are often easier said than done. PPMs must continue to develop and evolve their business models to optimize their value proposition and beat their competition.
- **Physician groups:** PPMs can be a real source of leverage, allowing doctors to practice medicine and thrive in today’s complex environment. Choosing the right partner will be the key challenge. In particular, long-term sustainability must be balanced against more attractive deal terms. Often if it looks too good to be true, it is.
- **Health Systems:** Rapid acquisition of physician practices, while successfully protecting referral volumes, has left many hospitals with severe physician practice management challenges. Hospitals, while better capitalized, are not particularly well-suited to deliver on key practice management gaps addressed by PPMs. And their problems are compounded by misaligned physician salary structures that inevitably lead to reduced productivity. Partnering with a PPM could provide unhappy hospitals with a better outcome than spinning groups back out at a loss or continuing with high levels of operational friction.
- **Payers:** A lack of sophistication in the provider networks’ ability to manage risk remains the biggest challenge to managing healthcare cost in the face of declining reimbursement and mandated medical loss ratios (MLRs). L.E.K. network analysis of risk-sharing feasibility indicates that on average only one-third of the network can effectively manage risk. Payers have the opportunity to leverage PPM penetration to drive network performance improvement – hopefully to better effect this time around.
- **Private equity investors:** The PPM space represents a strong macro-trend to invest behind. As always, successful investing will require understanding whether the fundamental value proposition is sound, the sub-sector reimbursement risks can be managed and whether the PPM is competitively well-positioned to grow.

3) "How do we collaborate effectively week in and week out?" Effective governance and operational protocols.

Although often overlooked, governance and operational protocols are critical to support the first two points above. Sound operating models ensure engagement and rapid issue resolution as well as provide an early warning signal for potential misalignment. They also provide an important platform for reaffirming the PPM's value to all stakeholders and minimizing the "what have you done for me lately?" complex.

4) "How is the toolkit optimized for my local market?" A local before national perspective.

Healthcare is a local business (a well-known maxim that is too often ignored). A PPM's capabilities must be tailored to help its companion physician group, whether owned or just supported, thrive in its local context, rather than to force the group to apply cookie-cutter national approaches that may be at odds with the local market dynamic.

Of course, even if these value drivers are kept in focus, there will be execution risk. The most likely stumbling blocks include managing and implementing systems across a diverse and often still independently minded portfolio of physician groups, the ability to bring actuarial expertise and translate it to clinical action, creating aligned incentives that work, and the challenges of potentially irrational competition for payer contracts. While these risks are real, we remain confident that PPMs will play an important role in the evolving healthcare-delivery landscape.

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