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The Doctor’s Bottom Line

Wall Street evaluates the physician practice management industry.

by Lawrence C. Marsh

The U.S. health care delivery market has shifted from one in which patients had total freedom to choose their physicians (a traditional fee-for-service practice model) to one in which the payer of physician services is much more influential in that physician selection (a managed care practice model). This shift clearly takes some control away from the caregiver and has provoked various reactions by providers. One clear response by physicians has been their attempt to increase their collective impact and organization in specific markets. Business writer Michael Porter suggests that intrinsic bargaining power is leverage that “suppliers” of services have over “buyers” (or vice versa), given their respective clout in a market. To gain better leverage, either the supplier or buyer seeks greater concentration than the “industry” it sells to or buys from. This effort at organization and greater concentration is a natural reaction to market change.

Attempts at physician organization have taken many forms, including loose multi-physician managed care contracting entities (generally referred to as independent practice associations, or IPAs), service contracts with management organizations, and the outsourcing of certain business functions to process experts. The formation of physician groups also has become more widespread in the United States. A particular type of physician organizational structure has emerged within the past five years: the broadly defined physician practice management (PPM) industry.

PPMs are defined in the industry as organizations that seek to combine the provision of outside professional business management, access to external capital (cash), and the offer of some purchase consideration (cash and/or stock) in exchange for the right to enter into a relationship with a physician group. A PPM is a management and business consultant, a bank, and a buyer, all wrapped into one. Unlike many other health care organizations, a PPM generally is nonaligned (meaning, not affiliated with either a payer or a hospital); financially motivated (meaning that the entity has been formed for the purpose of returning profit to its shareholders); and often structured with publicly traded shares of stock. Many types of organizations go by the name PPM: hospital contract service businesses, physician practice asset buyers, and business entities that are seeking to manage physicians in a wide variety of clinical specialties.

PPMs have generated great interest in the financial community, being viewed as efforts to improve the organization of health care delivery and overcome what Paul Starr has called a lack of “effective restraint.” In financial terms, physicians are considered the “means of production” in health care. Very little happens without their interaction: pharmaceutical prescriptions, lab testing, and hospital admissions all result from a physician’s intervention. Such broad influence creates great financial interest among physicians in investing in their “organization.”

Despite industry enthusiasm, investment in such physician organizations is a challeng-
ing business proposition. The goal of the PPM firm is a big one: to balance the needs of autonomous and powerful physicians, investors, regulators, and payers. Although some physicians may wish to maintain control of their practices and increase their compensation, PPMs generally strive to gain some measure of control over physicians, to achieve efficiencies and help to lower health care costs. Financial investors in PPMs seek to generate returns by participating in those companies that can demonstrate both profits (or the believable promise thereof) and growth. Regulators seek to maintain a clear separation between companies and medical care providers, especially when there is the potential for financial conflicts of interest. Payers seek to drive costs lower by reducing provider compensation and patient treatment intensity.

Does the above jumble preclude PPMs from being successful? Are PPMs really physician-led Faustian bargains cut with a latter-day financial Mephistopheles? We say no. We view a PPM’s key sustainable role as being a provider of reasonably priced capital (cash) and some expertise to physician groups as those groups seek to thrive (or survive) in an environment of more heavily prepaid care.

In this industry, success can be defined as the perhaps Utopian ideals of marrying physician satisfaction with patient happiness, with lowered costs and greater delivery efficiency, with appropriate care outcomes. The financial community would add an appropriate profit to those ideals. As outside observers, we find it difficult to quantify what may be inherently subjective in measurement: constituent satisfaction and quality outcomes. We find it much less difficult to measure financial returns, as demonstrated by profits to the companies, growth in those profits, and expanding share prices, as dictated by stock buyers and sellers. Those profits at PPMs ideally are accompanied by improved results at the affiliated physician groups.

We would be remiss if we did not note the important success stories in this industry, as measured by those figures that we can best understand (Exhibit 1). Certainly companies such as Pediatrix and ProMedco have met or exceeded their financial marks, with their respective shareholder bases enjoying nicely appreciating stocks. PhyCor also has demonstrated a strong record since its founding in 1988, with share prices having increased more than fivefold (as of the end of 1997) from initial public offering prices in 1992. However, alongside those successes are PPMs that have experienced real difficulties. In the next sections we identify several of these PPMs, to help the health care community gain insights into this industry.

A brief word on stock prices (as discussed in the company synopses that follow): Since many PPMs have publicly traded shares, prices accorded these shares can provide some indication as to how these companies are being perceived by the market. The more an investor is willing to pay today relative to current earnings, the greater the expectation of future earnings. Sometimes a PPM’s stock price actually drives a company’s operating decisions, for example, to grow quickly through affiliations and acquisitions. This can create changing and sometimes disruptive ownership and affiliation structures for both physicians and payers.

Four Examples

Pacific Physician Services. Pacific Physician Services was a primary care physician–based group of more than 100 doctors, based in the Inland Empire region of southern California (east of Los Angeles). The group was formed in the 1980s to be a subcontractor for California health maintenance organizations (HMOs) for the purpose of taking on partially capitated medical risk. Such capitated, or prepaid, care included all physician services and also included shared risk for inpatient hospitalization (Knox-Keene laws in California preclude medical groups from assuming full, or globally capitated, medical care risks, unless the group has been granted a limited Knox-Keene exemption through the own-
ership of one or more acute care hospitals). To facilitate its plans to expand, the company exchanged part of its ownership for roughly $20 million in initial publicly funded equity in 1992. Pacific Physician fits the aforementioned definition of a PPM. The company had developed treatment standardization and had enough reach in the market to be successful (as evidenced by its growing profits). Investors registered their excitement for this company’s prospects, bidding up its share price almost fourfold within one year.

This market excitement encouraged the organization to use its higher-priced stock to expand both through the affiliation with and the addition of new physician practices in existing and contiguous areas. Pacific Physician did just that and raised more money to accomplish this goal.

Unfortunately, building and expanding health care delivery networks do not always result in immediate boosts in profitability for care providers. Such was the reality of Pacific Physician’s expansion: It announced in March 1994 that it would not attain its expected profit growth goals for the following year; the announcement caused a meaningful drop in its share price. The company determined that it would need additional resources to grow at its desired pace and eventually sold itself to MedPartners, a larger PPM, in February 1996.

### Coastal Physician Group

Coastal Physician Group (formerly known as Coastal Healthcare Group) was an early public entrant (1991) in the physician hospital con-

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### EXHIBIT 1

<table>
<thead>
<tr>
<th>Net revenues (millions)</th>
<th>Percent market share</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“Owned” physician services (outpatient)</strong></td>
<td></td>
</tr>
<tr>
<td>MedPartners</td>
<td>2,500</td>
</tr>
<tr>
<td>PhyCor</td>
<td>1,340</td>
</tr>
<tr>
<td>FPA Medical</td>
<td>1,100</td>
</tr>
<tr>
<td>Talbert Medical Group (FHP)</td>
<td>455</td>
</tr>
<tr>
<td>Physicians Resource Group</td>
<td>400</td>
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<tr>
<td>PhyMatrix</td>
<td>155</td>
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<tr>
<td>Physician Reliance Group</td>
<td>210</td>
</tr>
<tr>
<td>ProMedCo</td>
<td>45</td>
</tr>
<tr>
<td>American Oncology</td>
<td>205</td>
</tr>
<tr>
<td>Occusystems c</td>
<td>155</td>
</tr>
<tr>
<td>MedCath</td>
<td>75</td>
</tr>
<tr>
<td><strong>“Provided” physician services (hospital services)</strong></td>
<td></td>
</tr>
<tr>
<td>Coastal Physician Group</td>
<td>580</td>
</tr>
<tr>
<td>InPhyNet a</td>
<td>410</td>
</tr>
<tr>
<td>PHP Healthcare</td>
<td>230</td>
</tr>
<tr>
<td>EmCare d</td>
<td>195</td>
</tr>
<tr>
<td>Sheridan Healthcare</td>
<td>95</td>
</tr>
<tr>
<td>Pediatrix</td>
<td>80</td>
</tr>
<tr>
<td><strong>Total subset market share</strong></td>
<td>197,000</td>
</tr>
</tbody>
</table>

**SOURCES:** Salomon Smith Barney; and Health Care Financing Administration.

| a | Acquired by MedPartners in 1997.
| b | Included in MedPartners.
| c | Merged with CRA Managed Care in 1997 to form Concentra.
| d | Acquired by Laidlaw in 1997.

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**Perspective:** Physician Practice Management
tracting/PPM industry. Its initial business-line focus was in the physician staffing component of hospital emergency department management. In 1993, however, motivated by concerns about significant market changes that would accompany federal government-initiated health care reform proposals, the company went on an aggressive expansion drive. It entered the managed care physician business through the acquisition of several Florida-based primary care physician groups, which added more than $150 million of revenues on top of existing revenues of $340 million in 1992. With these additions, and with the later purchase of a northern Florida HMO, Coastal started highlighting the opportunities it saw as a systems integrator, thereby seeking to reduce the traditional role of the HMO. In this case, the major feeder HMO was Humana, which represented close to 20 percent of Coastal’s revenues. Our discussions with Humana’s management at the time led us to note the company’s displeasure with Coastal’s acquisition of HealthPlan Southeast (the HMO) and its move to cut out its insurance middleman, given that it (Humana) was the main supplier of patients to the Coastal-owned physician clinics.

The combination of a strained relationship between the two companies, an increase in costs in the Florida market, the uncertainty of business-line expansion, and some lack of keen management oversight created profit troubles at Coastal. The company first officially signaled difficulties in early 1995 with some announced disenrollment from Humana in Florida and a more subdued outlook for the remainder of the year. That outlook for the company has gone from bad to worse since that time: Coastal’s results through the first nine months of 1997 highlighted net income losses topping $48 million. A combination of events caused company shares to fall substantially over that time period, going from a high of $40 per share to a recent price of less than $1 per share.

**AHI Healthcare Systems.** AHI Healthcare Systems was a PPM company with operations in California, Texas, and Georgia that was seeking to develop IPAs. The company completed its initial public offering of shares in September 1995. Part of its attraction as a PPM was its stated presence in several markets. Unfortunately, soon after its “coming-out” party, the company realized that it had underestimated the market-development costs it would incur in its eastern business; this realization led to a moderated profit outlook. Investors showed their displeasure by causing share prices to drop by some 50 percent (down to $6) on the day that information was disseminated. The company continued to struggle under development costs and highlighted further reductions in results in its second quarter of 1996 (a loss of $7 million). The company announced the hiring of a strategic adviser to explore its alternatives in 1996; later that year it announced that it was merging with FPA Medical Management in a share swap worth $8 per AHI share at the time of closing.

Apparently, AHI was not fully aware of the costs associated with seeking to grow as a PPM organization. This suggests that a PPM’s quest for market expansion and growth sometimes conflicts with investors’ interest in maximizing the growth of the PPM’s profits.

**PhyCor and MedPartners.** This is the case study that James Robinson discusses in his paper, which precedes my Perspective. On 29 October 1997 PhyCor announced that it would be acquiring MedPartners in a share offer that would create a $10 billion company with more than 35,000 affiliated physicians. The announcement was accompanied by weakness in PhyCor shares, as some investors struggled to understand the benefits of this combination of two very different organizations. The purpose of the combination, according to the companies, was to gain greater overall market concentration and to better influence organizational structure. PhyCor, the new dominant entity, was acquiring a company that was several times its size.

This union did not come to pass. In early January 1998 MedPartners made a sobering announcement: It anticipated a large restruc-
turing charge and an operating loss for its fourth quarter. It also announced, with Phy-Cor, that it was terminating the planned ac-
quisation. Shares dropped more than 50 per-
cent in value the following day. A change in the company’s chief executive officer came about the following week. MedPartners, after rapidly acquiring large, established practice groups and PPMs (Mullikin, Pacific Physician Services, Caremark, InPhyNet, Talbert, and Aetna’s PPM), had not been able to effectively coordinate and integrate the operations and cultures of these sometimes formerly compet-
ing groups. A week later PhyCor also an-
ounced that it would record a large charge in order to restructure some assets and to sell several smaller clinics.

Challenges And Opportunities

The experiences of these PPMs have much to teach participants in the health care market, for whom such structures may be foreign. First, there is quite a challenge involved in marrying the shorter-term time horizon of in-
vestors’ expectations for the PPM industry with the longer-term horizon of attempting to change physicians’ behavior and practice patterns. Because of this timing conflict, we pre-
dict that expectations in the PPM industry will continue to fluctuate. Second, this business strives to truly align the incentive struc-
tures of physicians and their business part-
tners (PPMs), so that both can benefit from practice improvement. But that alignment is still an elusive goal in a majority of the PPMs that we follow. Third, health care providers in today’s and tomorrow’s health care economy will need to build operating information infrastructures, to interact more directly with patient care (through care risk taking and through the greater provision of ancillary services). Although some of the character-
istics of this industry do not lend them-
themselves to Wall Street’s mentality, other as-
pects fall within the realm of what true equity partners can do for health care entities.

The opportunity and the great challenge for the PPM industry is to take the particulars

that are now misaligned and seek to right them. The ultimate outcome of that task will determine whether tomorrow’s PPM case studies will be those of great successes or those of unfulfilled promise.

NOTES
1. M. Porter, Competitive Strategy: Techniques for Ana-
3. Examples of hospital contract service companies called PPMs include Pediatric and EmCare (recently acquired by Laidlaw); physician practice asset buyers include many PPMs, including Phy-
Cor and ProMedCo. Physician specialties that are being managed by PPMs range from orthope-
dics to cardiology to oncology to ophthalmology.
4. P. Starr, The Social Transformation of American Medi-
5. Pacific Physician Services shares, which were first traded at $7.35 per share (stock split-ad-
justed) in May 1992, were bid up in value over the consequent year and rose as high as $29 by early 1993.
6. Coastal Healthcare Group, “Coastal Healthcare Group Completes Acquisition of Primary Care Network” (Press release, 1 July 1993), and “Coastal Healthcare Group to Acquire Two Health-Care Networ-
s” (Press release, 27 January 1994).
7. Coastal Healthcare Group, “Coastal Healthcare Group Completes Acquisition of Health Enter-
prises” (Press release, 11 November 1994).
9. Coastal Healthcare Group, “Coastal Healthcare Group Announces Third Quarter and Nine Month Financial Results” (Press release, 1 No-
ember 1997).
10. J.C. Robinson, “Financial Capital and Intellec-