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Physician Practice Management

Marc H. Auerbach

Jeffrey L. Cohen

Jay Martus

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VII. PHYSICIAN PRACTICE MANAGEMENT

TIM RAVICH: . . . Our final panel [will discuss PPMs or Physician Practice Management Companies]. I'll present the panelists from the my left to right.

First is **MARC AUERBACH**. He is a partner in the Miami office of the law firm of Kirkpatrick & Lockhart. Mr. Auerbach attained his law degree *cum laude* from Temple University. Mr. Auerbach practices primarily in the areas of health and corporate law. His focus is on structuring and negotiating transactions with an emphases on financing and structural issues and issues related to the development of new business. Marc also provides general representation to a wide range of health care entities, including physicians groups, HMOs, hospitals, PPMs, IPAs, diagnostic facilities, and equipment manufacturers. Such representation ranges from rendering advice on fraud and abuse issues, developing compensation structures, and assisting in the purchase or sale of a variety of entities of physician groups. Marc, thank you for helping put this Symposium together.

Next is **JEFFREY L. COHEN**. In organizing this Symposium, Jeff was among the first to be contacted and was, in fact, the first person to commit to participating.

Jeff Cohen was inhouse counsel for the Florida Medical Association until 1993, when he was recruited to head up a Ft. Lauderdale health care practice. He is currently a shareholder of Strawn, Monaghan & Cohen P.A., and is Board Certified by the Florida Board as an expert in health care law. His practice is devoted 100% to representing health care professionals, hospitals and other health care facilities in transactional matters. Mr. Cohen is a member of the American Health Lawyers Association, the Doctors Advisory Network of the American Medical Association, the American Society for Medical Association Council, and the Florida Hospital Association. He served as a member of the Executive Committee of the Health Law Section of the Florida Bar from 1994 to 1997 and has chaired the Managed Care Division of the health law sections. Also, Mr. Cohen was a member of the Antitrust Advisory Committee to the Agency for Health Care Administration in 1993. Mr. Cohen is also an Adjunct Professor at Nova Southeastern University. Additionally Mr. Cohen was named "Best Health Care Attorney" at the 1995 Medical Business Health Care Awards and has been selected by his peers as the leading health care attorney. Mr. Cohen is a frequent lecturer and author on health care law topics. Jeff again thanks for being here.

JAY MARTUS was, similarly, one of an initial group of significant practitioners to commit to this Symposium. Jay is a sincere supporter of the University of Miami and to any cause that will promote it. Jay is a graduate of the University of Miami School of Law, receiving his degree *summa cum*

laude. He was a member of the *University of Miami Law Review*, president of the Moot Court Board, and a member of the Iron Arrow Honor Society. We are delighted to have him. Mr. Martus represents Sheridan Health Corp., serving as inhouse counsel since 1994. Jay, thanks for your help.

With that, I will turn [the forum] over to the panelists.

JEFF COHEN: Thanks very much Tim. I am going to introduce just very briefly the overview where I think we are going to go and what I hope you will walk away with.

But, just to give you, those of you who aren't familiar with some of the panel members. You've really got a great representation of the industry. Jay [Martus] is probably the only person who has really been, that I know of involved with the single start to finish transmigration to PPMC business. And Marc [Auerbach], of course, has been involved primarily [on] the other side representing people doing business with that industry since its inception. So, it's a tremendous wealth of knowledge and experience and I'm very interested in particular to some of the things they have to say about, in particular, where the industry is going.

What I would like to do is just give you an idea of some of the things that I'm doing and seeing in the industry. And then turn it over to Marc [Auerbach] and obviously to Jay [Martus]. And what I hope you walk away with and get a sense of where the PPM industry is today and where it's going — some of the transmutations. Because it is, as you know, an industry in great turmoil and chaos and opportunity, depending on your perspective [. . .]. For fun I looked up on the internet, in particular, the muscular-skeletal portion of the PPMC industry which is very hard hit. Just to give you an idea: the fifty-two week range for BMJ Medical Management is now trading at 1/16th; the highest was 8-8/75. It is now in Chapter 11 in Delaware . . . it has been subject of multiple shareholder derivative actions and underwriter derivative actions [. . .] Integrated Orthopedics, fifty-two week range: 1-1/68 to 7.12; it is now at 1-13/16 . . . — Obviously an industry that has been tremendously hit. In my opinion, and I am going to speak in broader terms, and try and stay away from some of the technical issues because I think they have been handled thoroughly well before we got here — but I think in some respect the industry has been hard hit in a deserving fashion in some respects and in a nondeserving fashion.

There are those, myself among them, who feel that some of the PPMC businesses are grossly undervalued for what they do; and there are some parts of that industry, I feel but for the arbitrage portion of their business, never would have been in business, never will be in business and there is no place for them in the market. The services that physicians that we are looking for in affiliating with PPMCs were in my experience, in many respects, ghost

services. And there seem to be two ways to ramp up to get those services for PPMCs. Either you do that pre-IPO or you do it post-IPO and either way you have to have a very strong management-services core. And I think one of the huge failings of the industry is that it failed to deliver those services. It failed to be able to have the wherewithal, and to ever provide those services.

Backing up just a bit, I think it's important to distinguish between PPMCs, which I consider to be pure PPMCs, and PPMC's which I think are more akin to group practices. Those practices, like Pediatrics and Sheridan, are really in my opinion fit more in the group practice mode in the sense they have a great deal of control and a great deal of integration among the practices. It's more of an employment model business. Those practices I think are doing very well and I think there will be a place for them in the future. And I think they are being unfairly hit by the market. The other PPMCs like BMJ and [. . .] and MedPartners and Phymatrix, — those other businesses which have found that arbitrage move has forced them out of the market. Those businesses in that model, I would be shocked to see resurrected in any form.

One of the things I used to do a lot of is do these PPMC deals on behalf of physicians and physician groups. I've never represented a PPMC. And now a lot of what I'm doing is unwinding those deals. I'd say half of my time is spent unwinding the PPMC deals. And I thought it would be kind of fun to give you an idea of two of those unwinds. What it looked like going in and what it looked like coming out, just on the business side.

Group one, physicians received \$1.3 million. Their assets were purchased, their ARs [accounts receivables] were purchased, their obligations were assumed. Within a year and a half, they were offered the opportunity to take back their ARs, their receivables, take back their assets and to receive another \$1.3 million to unwind that transaction. So they got to sell it twice, in essence. And of course, they walked away very happy with that transaction. Another transaction was \$2.3 million was the sell price, cash at closing, no stock. Great foresight for them because the stock is now worth paper. Their deal, last I checked was \$700,000 cash. They get ARs back, which are about 750 gross, — collectable is somewhere around 350, 400. They get their assets back, they have to reassume, obviously, all their old business obligations, the leases — and what have you, \$700,000. That deal is one year old. They got capital gains treatment on the purchase price for the 2.3, all of it. So, what seems to be happening is that those who are waiting — the deals are getting better in the unwinds. I think some of the problems that the PPMCs are experiencing are self wrought in the sense that they've announced that they do not want to be in the business, I think that by doing that, that was kind of blood in the water. And the physicians and their counsel have really looked to take advantage of the circumstances. And I think it's working very well for the doctors. At the end of the day, the irony, I think, for the doctors has been

that, yeah this has not been the greatest experience for them, — these traditional peer PPMCs. But, on the other hand, I haven't seen one, in my experience, who [hasn't] come out economically far ahead of where they began.

From there I'm going to pass it off to Marc . . .

MARC AUERBACH: . . . Thanks. A lot of my practice focuses on the physician's side. But I think it's helpful to give a little background — the way physicians think, and the way they come to these type of deals, and why they are . . ., you know, these practice management groups in the first place. I think if you ask most physicians, especially the ones who have been around for a while — they would have liked it [the way it] was in the old days when there was private pay and Medicare, Medicaid and they went in, they did their work and they got paid. Unfortunately, from that perspective, HMOs came around and hospital chains became for-profit, and were developing their own networks — so that they felt they needed a mechanism to respond to that. At the same time that managed care industries [were] growing. You got a lot more regulation both at the federal level and the state level. . . . Both federal and state legislation kind of left a loophole, at least the way the physicians looked at it, which was the group practice loophole. A lot of physicians [are] going away from what they had traditionally liked to do which was to have one, two, maybe three physicians. As they got more senior they would bring in a younger guy and they were forced to get into the group practice modality because that way they had to treat patients to survive. Then, when they were finally used to that idea, Wall Street gets involved. And all of a sudden, you have a lot of people who were never involved in the health care industry at all; and they're out there and they're developing these economic models and their colleagues are all caught up and [saying,] "Can't believe what these people are paying. I've got to get in. Find me a deal. Find me a deal!"

On the way over I tried to jot down some of the things, I think, it's important I think, from the lawyers stand point. The lawyers think that the laws are all fair and these physicians are reading the laws and reacting to the laws. That's really not what's happening. What's happening is there's a business environment out there. And they are reacting to the business environment and hopefully . . . and then before they do something, but a lot of times after they do something they will call up their lawyers and say, "This is what I want to do and this is what I've done. Is it O.K.?" So, I think it complicates the matter for lawyers. I think the practice management companies have had some successes and have had some glaring failures in trying to address, at least what the physicians perceived as what they wanted to get out of the practice management companies.

I just want to run through a few of them because I think it's important to get the mindset of the physicians. And when Jay [Martus] speaks you'll get

the mindset of the practice management companies and kind of run through what the physicians are looking for [and] what they actually got and then to try to leave at the end, real quickly where I think the physicians are going, — and probably where I think the practice management companies are going very generally.

What the physicians look for first-and-foremost, I think, is they wanted compensation for what they perceived as what they have built up in value in their practice. They have been out in practice, five, ten, fifteen, twenty years and they felt they had built up a certain value in their practice and they wanted to get this value out when they sold. And I think the practice management companies did, probably, too good a job in that area and that they overpaid in that portion of it, and put a lot of cash in physician's hands. So, with respect to that, what the physicians were looking for and what the practice management companies were providing ended up pretty good. I think the physicians got a better deal than they probably deserved. The other thing the physician was looking for was growth. And not growth necessarily in terms of getting more contracts, but what I would consider using a retail concept, "same store growth." They wanted to enhance their specific practice and have that practice grow.

I think there's a mixed bag with respect to how the practice management companies have done in that area. I think, the primary problem they have had is, I think most of the practice management companies didn't understand what incentivised physicians and didn't build in enough incentives in the contractual relationships that they had. The practice management companies that have done well in that area are the group practice models, where they have you treated; the physicians [work] more as part of team and integrate them as employees. There has also been good growth in the practice management companies that have focused on practices where there's a lot of ancillary services involved, so that the practice management companies came in with capital and we are able to go out perhaps to get some equipment that perhaps the physicians were not able to secure individually and they are able to grow through that area.

The other main area I think the physicians were looking for was professional management. I think, that's an area, I think by-and-large the practice management companies have not done a good job to date. I think they are getting better but I think initially what happens is a lot of these practice management companies had a Wall Street mentality and these are business people and not necessarily people who had experience in the health care field. Although I think that's changing and it's getting better. It wasn't there in the beginning. This is a problem . . . not unique to the practice management companies. The other entities who are out there acquiring physician practices are hospital chains. I think a lot of the hospital chains

went out and said, "We can run our hospitals, we really know what we are doing and we're going to go out and buy these practices." And what's becoming readily apparent is most hospitals may be very good on the Part A side but they really don't know how to run the Part B side which is the physician practices; and as a general rule they have been really poor at it, in my personal opinion. I think the physicians look for some kinds of economies of scale as being involved with the larger entities.

I think the practice management companies have done a pretty good job in certain specific areas. They've helped reduce malpractice rates, with respect to some kind of supplies — in some — purchasing, they've done a pretty good job in that area.

I think [an]other thing that physicians looked in, I kind of lump it together, which was access to capital, access to technology. There has been a pretty good success rate in that area except a lot of it was the brass ring that they were not able to grab. I represented a physician group that people came to them and said, "Well, come with us. We have all this technology and we are going to put in computerized billing. This is a wonderful thing. We are going to put in computerized medical records." And the doctors loved this idea, — "Computerized medical records, it's the wave of the future. Let's do it. Let's do it." And they called me and I said, "That's very nice, but in Florida the Board of Medicine still requires you to have paper records as well, so, the computer medical records are really, — it's time hasn't come yet because Florida hasn't moved into the next century yet!" So I think while technology access has been good, it hasn't been as good as the physicians anticipated.

The last two things were [physicians] viewed [physician management companies] as an investment vehicle. A lot of physicians said, "We'll give the stock, fantastic. We're going to retire. We give them these cheap stocks and we're going to retire." Unfortunately, in almost every instance the cheap stock got much cheaper. And then the final thing was contract leverage. The ability to go out and get these big managed care contracts. And I think that in that area it was really a hodge-podge. Some of the practice management companies have been very good in securing contracts. Some of them have been marginally successful at best. The physicians generally have a mixed view point, but I don't think the experience has been what they expected of it. Just very briefly, — some of things that physicians groups that I've represented and other physician groups that I know that are going to try and operate in this environment outside the scope of the physician management companies. I think you've seen kind of the hybrid of it which is the physicians who said, "We don't need, you know, the Wall Street types. We'll go out and form our own physician management companies." So you're seeing the second generation practice management companies which have been the physician-owned ones. And they're sales pitch is, "We're run by doctors, we

understand doctors and we'll do a better job." The jury is still out on that. I'm not convinced that that model really works.

A lot of physician groups have gone to what I call "Vertical Integration." And vertical integration in certain specialties has worked very well in my opinion. For example, [consider] if you have group of noninvasive cardiologists and they are trying to see how they want to react to the market place. What they may decide to do is go out and bring in an invasive cardiologist, they'll bring in a cardiac surgeon. So they are kind of going upstream vertically and then they go downstream vertically and they'll bring in a bunch of internal medicine guys to kind of feed the pipeline. And that model [has] worked pretty well if you happen to be fortunate enough to practice in a specialty that allows for vertical integration. I think, if you read the paper you see an interesting response, I think an interesting physician response is probably now more than any time when I've been practicing; you see, really, some inroads in the labor movement. And for the first time you're really seeing the unions are penetrating the physician marketplace. When I started practicing that was unheard of. No physician would join the union or very, very few [would]. I think that's changed and you are now seeing the classic response to the business community to large contracting parties on one side. What they are doing is unionizing, and where that goes I don't know. I think that's another interesting area I think you should keep your eyes on because I think physician unions are probably going to become more prevalent in Florida. It's one of the areas that they are targeting.

Physicians have also expanded into related fields. . . . [W]hat I mean by that is I have physicians that have gone out and got their third party administrator license, "TPA licenses." They've formed their own management companies. They've gotten into software products, where they have developed software protocols and software credentialing. And now they are becoming software marketers. Another area that they've gotten involved with is clinical studies. And now the practice management companies are kind of following suit. The whole clinical study industry is taking off a little bit. And finally, you're kind of seeing the flip side of it is, I think I may be wrong, I think it's the [. . .] clinic, the orthopedic clinic, where now the physician practices are saying, "We don't want the hospitals buying us, we want the practice; we're going to go out and buy everything." And they're negotiating to actually go out and buy hospitals and taking vertical integration one step even further on the evolutionary chain and now they are going to own the hospital as well. We'll see if the people who know Part B can manage Part A any better than the other way around.

The other things I'm seeing a little of is kind of little niches. There's more attention to the pharmacy field. A lot of the physicians groups, especially the primary care groups are trying to form what I call "EPOs,"

where they are trying to have one large employer where they will go to the employer and say, "We are primary care physicians, we'll service all your employees on some kind of set fee bases, either a capitated or discounted fee," — there is a broad spectrum of that — and that's starting now with very large employers — to take hold [. . .] mainly with pharmacy products and primary care, [. . .].

Finally I think that physicians in certain areas are getting into the lobbying mode, I think one of the panelists in the presentation before us talked about lobbying to get rid of *Bakarania*.¹ They really, in my opinion, have not done much lobbying in that area, but they certainly have been doing lobbying in the area of open access, mandated coverage. This is what I would call "super coverage" for managed care entities where, for instance, in the area of diabetes, [. . .] the HMO law basically mandated that the managed care companies had to cover all aspects of diabetes. There is lobbying going on. I don't know of any specific lobbying dealing with *Bakarania*-type issues, but the physicians have evolved a little bit and they do understand lobbying that may play a role. My personal opinion is some of the dinosaurs on the physician side [. . .], and they're going to evolve into PACs, in my opinion. And they are going to become some what of a lobbying entity.

Real brief, I don't want to steal Jay [Martus'] thunder: I think practice management companies are going to be here, they are going to survive, they are going to evolve a little bit. I went through a short list but I'll let Jay [Martus] expand — but what my physicians are looking for, and I think what the practice management companies are looking for — I think you are going to see lower upfront purchases; the dollar amount is going to go down. There is going to be real due diligence. I tell my physicians, "You really got to clean up your act; the practice management companies are really going to do due diligence. They are not going to play arbitrage game, where they buy in at a multiple of 6, they don't care if it's profitable because they are selling at a multiple of 20, they're going to want to see you can make a profit." I think you are going to see an incentive-based compensation. And if you take that even further, I think you are going to see true employees, which is the model I think probably works. You are going to see shorter range management contracts — management contracts without the failure to perform. I think there is going to be a focus on real benefits. I think in terms of ancillary, in terms of technology, — I read an article recently that most physician practice computers aren't Y2K compliant. I think the sophisticated management company is going to come in and say, "Well, you know, we are Y2K compliant, we'll

¹ See Section VI, The Role of the Florida Board of Medicine and the *Bakarania* Decision, *supra* p. 450.

make sure all your billing is done.” In the short run, I think you are going to see more of that. I think there is still going to be some consolidation in the industry, but right now I think the practice management companies are probably undervalued and I think the successful ones — and Jay [Martus] will probably tell you about this more — the successful ones recognize that and are trying to take traditional tactical measures to secure that value. I think you probably saw in the paper that Pediatrics has adopted a poison pill to make it less attractive to potential suitors. So, I think a lot of these industries go through cycles. It’s in a down cycle now. I don’t think the industry is gone, I think it’s here to stay. I think it will evolve somewhat to be more sophisticated, more streamlined. But I think it’s here to stay and I think the physicians recognize that and the physicians are gearing up to deal with it.

Jay [Martus] you’re the other side of the story . . .

JAY MARTUS: . . . I’m general counsel of [Sheridan Healthcorp]. . . . I want to step back a little bit, I think it’s important to understand I view myself not as the general counsel of a physician practice management company, I view myself as being an attorney who, for fifteen years, has represented providers. And I view this as, really, we have to step back out of the mind set of this being the physician practice management field and look at this in its traditional lens. There it is a triad of health care that we’ve looked at traditionally over the years, which has been between hospitals, the providers, and the payors. Today they’re called managed care companies, but a little before I started practicing they were indemnity companies. Then, we started seeing HMOs. And now we’re seeing a new hybrid coming out of the managed care companies. Hospitals, short-term less acute care facilities are now evolving. We have seen a variety of combat over who controls the health care dollar profits. Is it the payor? Is it the provider? Is it the hospital or the long-term facility that are getting those dollars? That has lead to an evolution in the last ten years, which has seen things like IPAs, PHOs MSOs. And MSOs were the precursor. MSOs, Management Service Organizations, were the precursor to the physician practice management companies. In Florida there was no need for a physician practice management company because we do not have the corporate practice of management doctrine.

My company is in seven states, with 56 facilities, with 350 physicians. We have about \$125 million in annual revenues. Quite frankly, until 1994, we were only in Florida. We were really basically a group practice. We did a leveraged buyout and a year later we went public to take advantage of a capital market to acquire additional practices and go into different markets. What has happened? Companies like ours which are really bona fide group practice models had taken advantage of a structure which was a long-term management services organization relationship and used that structure, even

in states where it wasn't necessary like Florida. Why did we do that? We did that for one reason: because the Securities and Exchange Commission permitted us to amortize the value over the fair market value of the assets, which is known as good will, over a forty year period. By doing that on an accounting bases we could stretch the value and the profitability in the earnings of that practice that we acquired and show a greater profitability to Wall Street and get a higher multiple; it was the darling of Wall Street. That, combined with the movement towards capitated contracts or contracts where you are not paid a fee-for-service but a dollar amount per member per month to take care of all the health care services of a population, appeared to be to Wall Street and to everybody else, as these pie-in-the-sky, rainbows with a pot of gold at the end of the tunnel. Well what happened? The Securities and Exchange Commission created a group called the "EITF," the Emerging Issues Task Force. They decided, "Gosh, you know, these mandated service arrangements, even though they are forty years in duration, — think maybe they don't have a useful life at that time" — and they reduced it back to twenty years. Well companies like ours went back and we adjusted our accounting, and we went back and began to look at these management services relationships and say, "In states where we could employ the physician, — what's the benefit of having this extra piece of verbiage, this extra piece of relationship where we don't actually have greater control and integration of those positions?" So we began to put in devices which would allow us to get rid of them at will.

We, instead of just simply having a management services arrangement, — we also had a parallel to that which was an option agreement to buy all the shares of the stock of the corporation for \$100, so that we could essentially acquire the practice, use the MSO, take advantage of this earnings write-off advantage until such time as there was a problem. Well, boom, thank you very much, the Board of Medicine comes up with *Bakarania*. *Bakarania* looks at these percentage of revenues relationships and they say, "Gosh, you know that's really fee splitting." By the way I totally disagree that it's fee splitting. I think that Marshall [Burack] said it properly, that it's basically an *ultra vires* act of the Board of Medicine. But who cares? Because in Florida, I can employ you. I exercise my option, I employ you, I integrate my model. It doesn't make any sense. I don't recall who the panelist was in the prior panel but they talked about this and they said — I think it was [Alberto Hernandez] — "I think it's stupid because its form over substance. I can do everything I want as an employer, as a physician practice management company that I can't do in a PPMC, MSO model, by doing it in a direct employee-employer model — anything I want, and not have a problem whatsoever with the Board of Medicine." So to me, as far as its impact on the industry and PPMCs, if you can approach this as a true group practice model and you could take out the

problem of having an unnecessary MSO relationship, *Bakarania* doesn't matter. It's something that everyone structured. Now if you had the foresight to have these clauses and have alternative structures such as options and have the opportunity to go forward you don't need to worry about unwinding. And because this market was overheated, because the public sector presented these tremendous multiples, — Wall Street handing out dollars left and right, — there were a number of PPMs that went out there, didn't have the foresight, the thinking to structure deals, knowing that the regulatory scheme changes day to day, and [the thinking] that you have the key to being successful in the health care industry whether you are a hospital, whether you are a payor, whether you are a physician group, a provider group, a PPMC, whatever you want to call it, — is to maintain structures which enable you to be flexible in an ever-changing regulatory environment. And the successful PPMs will become whatever the next name isn't tainted on Wall Street. And in two or three years, companies like ourselves will come back out again. And will come back out again stronger, with more earnings, with more foresight, and will go back to the core values that creates value. Exactly what you were saying, Marc [Auerbach].

The core values that we look for when putting deals together are bringing together synergies of providers. We have started out traditionally as an anesthesia company, and as an anesthesia company we're hospital based. In 1990, when I really began to become the counsel, 1989, 1990, when I became the counsel for this group — we were vulnerable. We were vulnerable to the managed care companies coming in telling the hospital administrators, "You know that anesthesia group has too high a fee and if they had lower fees we'd bring more patients into you hospital." It wasn't true, but that was the argument that was often used. And we were vulnerable. We were vulnerable for them bringing in someone else to replace us in that circumstance. Well if we could bring in, and buy things that were complementary to that anesthesia contract such as ObGYN, and surgery practices and protect that interest because we now not only have the hospital-based services but have services which are complementary and bring revenue to that hospital. Now we have leverage with one aspect to the triad, the hospital. We have leverage with the other aspect of the triad, the managed care companies. And guess what? We can create true value for everyone in the game, which doesn't take money out of the mouths of the doctors.

How do we do that? Let's take Dr. X. Dr. X is in [an . . .] area between two facilities. Dr. X is an ObGYN. He takes his business and instead of providing it and splitting it between two hospitals, he brings it over here to the hospital where we have anesthesia, neonatology, pediatric intensive care, and he now replicates his earnings, he gets his money, and we get an increased boost as a result of that integration into a true group practice model. And the

hospital sees additional value. Everyone wins. And the managed care company has less leverage with both the hospital and the providers. Those are the types of values that can come about.

Talking about incentives, the way we structure our transactions, the way most successful PPMs structure their transactions is to pay a multiple of earnings which correlates to reasonable term of the employment relationship with the physician. So let's say you are going to have a five year relationship with that physician, and you're going to pay them a four multiple or five multiple of their earnings. Let me explain to you what that means because it's important for you to understand our business. Dr. X makes a million dollars a year today, that's a million dollars of earnings, — his revenue. Fifty percent of that million dollars go to pay his practices expenses so he really only makes \$500,000. He puts the \$500,000 in his pocket. If Dr. X was recruited out of medical school and he were 3 or 4 years out and he wasn't an owner of that practice he would be paid \$250,000 a year for that practice. If Dr. X sells me the \$500,000 less the \$250,000 of earning and I pay him five times, he gets a million dollars in his pocket, that's the compensation for equity [Marc Auerbach discussed previously]. The other \$250,000 is his salary going forward. If he replicates his earnings going forward on the five years and he only works for five years, unless I can replace him successfully, I'll lose money. Oh, it's because of tax, and amortization of good will and those things. Because I really need to keep him incentivized and keep myself incentivized to keep in the practice. So if I give him an incentive compensation, — once he reaches \$250,000 or \$500,000 of earnings going forward and pay him a percentage of the excess that he generates above that, let's say 40% or 50% of those dollars and I keep the balance of that, it's perfectly legal in Florida, because, quite frankly, it's an employee-employer model. He has all the benefit and all the incentive going forward of doing these transactions. This is the type of model which most of the PPMs *aren't* using.

The PPM industry is riddled with the experiences of the last three years. Coastal Health Care was the first major corpse to come along. It still exists. I shouldn't call it a corpse; it still exists, but it went from \$55 a share to a dollar or two dollars a share. And the reason it went there is because it decided to go into the capitation business. It went in [and] decided to take on Humana; it was again a provider taking on a managed care, — basically everybody talks about it as the PPM industry, it's really providers, hospitals, and payors. They took them on, they weren't able to adequately assess, — as no one is, — the incurred but not reported claims and the company crashed and burned because it did not meet the expectations of the Wall Street analysts. The second one to crash and burn was really FPA. FPA, except for a physician practice group of emergency physicians known as Sterling, was really nothing more than a shell, again trying to pull together without any

value, a group of networking arrangements with physicians . . . adding no true real value, having no true integration, having no true management. The MedPartners and Phycore-MedPartners was nothing more than an offshoot of HealthSouth, which was a very successful hospital piece of the triad, [which] decided to offshoot into the physician area to try to put everything and anything they can and use the model Marc [Auerbach] was describing, — buy at six, have a multiple of twenty. Two years ago touted as being the next great monolith of health care, they bought the Mulligan Group, which is the only true multi-group practice in California. And that was the peak, they were a billion and a half dollar entity. The problem was there was no synergy, there was no integrative plan, the practices didn't know what they were doing, they weren't working on a coordinated basis for managed care contracting.

All I'm trying to tell you today is that the physician's portion of the triad is extraordinarily fragmented today, yet it is the portion of the triad that produces the value in health care services. It is the portion of the triad that will be the one that dictates what goes on going forward. Hospitals are overbuilt and underutilized. They're closing in droves. They will never be what they were once in the past. The federal government has seen to that with DRGs, reimbursements, and they will never ever be there again. Managed care companies, surprise surprise, are beginning to feel the sting. [. . .] Why? People are angry. They're angry that the plans systematically do not provide value for the dollars that are paid. Why is that? The typical or average percentage of the amount of premiums paid by managed care companies that goes to the managed care companies is 25%. What does it cost them to produce that 25% of the premium? Less than four percent on average. How are they able to do that? They are able to do that because unintended insulation from malpractice liability through ERISA, which is eroding as fast as you can say the word "ERISA." They have the ability because the market of physicians is so fragmented that they are able to dominate and undercompensate those physicians for services that they provided. Everybody has seen the physicians attempt, and PPMs are just merely one manifestation of that to counteract the power and the leverage of managed care or payor organizations. PHOs were the first attempt, — then IPAs, foundations, group purchasing, group contracting. The only true way to combat at this stage is through bona fide group practice models which take over and provide true value and market value for services where they cannot be exploited by taking one portion of the triad and using it against the other portion of the triad. In other words, physicians have to be compensated for true and fair value. It's going to happen through regulatory reform upon the state legislative basis.

There are currently 37 states in the United States of America today, as we speak, that have current proposals to reform managed care legislation both in terms of payor reimbursement practices, both in terms of open access, both in

terms of the ability for physicians and members to have true assessment of the fair value of the cost and reimbursement for services and that's only going to escalate. And on a federal level, I think there are currently six different bills pending before Congress, — virtually identical to the same types of subject matter in the 37 states. What does it spell out for our industry going forward? I really can't tell you what the shape or dimension of the PPMC industry will be. Quite frankly, I don't view it as a PPMC vision, that's a Wall Street label that was created in the last five years or six years. And quite frankly, I view it as being a transitory phase for the integration and defragmentation of the provider sector.

JEFF COHEN: I think just to follow up on a few things that Jay [Martus] said — the interesting thing about all of these business models, whether it's a PPMC, IPA, PHO, group practice what ever it is, we're always talking about how to improve the physician's position in a market of shrinking reimbursement. And that's really what the PPMs are. They are a, I think for physician's anyway, they are a way that physicians view their position in the market as being improved through enhanced services, enhanced purchasing and access to capital and what have you. That's going to continue. Those that did not get what they came for are going to continue. And I think it's very interesting, I think all of us agree that, and probably all of us in this room that practice in the health care field agree that the king of the models is a group practice model of some sort, and full integration is better than partial and it just works better and delivers better bottom line services.

JAY MARTUS: And by the way — let me just interject, I think it doesn't matter whether you are in a corporate practice medicine state or not. We are in corporate practice of medicine states and we have group practice models. And the manner in which we provide those services are to, in fact, strip out the issues that arise in *Bakarania*. One thing that wasn't mentioned in the *Bakarania* discussion is that OIG and it's Advisory Opinion 98-4², virtually paralleled some of the language of *Bakarania*. With respect to percentage of revenues and whether that's a fee splitting arrangement, which may be violative of fraud and abuse. I mean, from a federal level, that's a much more troublesome pronouncement than *Bakarania*. But the bottom line is the same value can be had, the same defragmentation of the industry can happen, whether it's in a corporate practice state or not. [. . .] the nonmedical, nonclinical side needs to be rationalized in fair market value. Look, in order to be a truly successful physician practice management company you have to

² Issued April 15, 1998.

take the true value of the measure of the services and value of those services out and leave the remainder to the physicians or it will not be successful going forward. And so the answer is: It's very simple. There is no huge pot of gold at the end of the rainbow other than hard work and growth. And that's the answer to successful physician practice management companies.

MARC AUERBACH: I would add one piece to that. I think from representing the physicians and seeing what the physicians are really looking for and I think certain of the practice management companies have come a long, long way. The physicians want to feel they are involved in the decision-making process. You know, historically I think, a lot of people looked [at] physicians [and said,] "They are there just to provide the care to the individuals. They don't know anything about the business, — wear the suits, we'll take care of it." [. . .], I think the practice management companies and the other entities at least recognize that the modern physician is a lot more sophisticated about the business environment and most of the modern physicians are willing to be business partners with the practice management companies. They're not opposed to the practice management company making money as long as they are making money in partnership with them. And I think the practice management companies that come around to that view point are the ones that are really successful.

JEFF COHEN: I think that's what you were saying Jay [Martus], — that one of the problems in looking at PPMCs from the physician's aspect, most doctors who deal with most PPMCs feel unaligned. They don't feel that they are getting their due from the PPMC. That's the huge difference between a company like Pediatrics or maybe Sheridan and some of the other companies that are not in business today.

JAY MARTUS: I think from our perspective, the real issue in terms of running the practices — we leave it to the physicians in the practices. I mean, let them basically make all the decisions except obviously, we put in those modern things that we need to deal with such as ADA, compliance issues with sexual harassment issues, with respect to risk management, OSHA, the regulatory overlays which are very welcomed and we include them in those processes and those thinkings. We have internalized peer review processings. I think you'll see the more progressive PPMCs, they're nothing more than an extension of what it was for our company in 1994 when it was completely physician-owned and physician run.

JEFF COHEN: I think that's a huge difference, because your company started out actually providing services to physicians. Most of these companies started

out as an arbitrage, or financial play and tried to bring the operation in around them.

JAY MARTUS: But I think this discussion is not about Sheridan Healthcare. This discussion is about the industry. And unless physicians continue to push and become a part of integration processes, they are going to continue to be squeezed harder and harder by the payor dollars and the governmental dollars. And there's nothing more compelling to the [concept of] change than the pocketbook and this is what is happening. The concept of, — the description that was made of the Board of Medicine as being the older, more successful physician, — those days of fee-for-service, seven-figure incomes are over. The number of physicians who have seven-figure incomes has dwindled dramatically. And the number of physicians whose incomes are above a half-a-million dollars a year has dwindled dramatically. And the only way physicians will continue to receive fair value for their services is to come together in some form or another in an integrated fashion. And PPMCs [are] merely a transitory phase in that evolutionary process.

JEFF COHEN: And I think one of the questions that's going to hang out there from this industry's crash is: Can anybody other than physicians do this? I think, in theory, that's true but in practice most physicians don't trust it and are going to trust it even less.

JAY MARTUS: The key is physicians have to be intimately involved in that process. Because only physicians can really decide what's appropriate and necessary for the provision of medical services with a standard of care and know what they need in order to appropriately take care of their patients — and will feel alienated and not a part of that if they are not aligned with that process in a rational business organization.

MARC AUERBACH: I agree with you Jay [Martus]. I believe one can't survive without the other to be honest with you. I think the practice management companies offer some of the services you were talking about are notoriously bad and vice versa.

JEFF COHEN: It's interesting. One of the terms *de jure* that I just picked up on the internet when I was flipping around the other day is the "FIP," a flip on PPMCs, the FIP. I never heard of it before. It's called a "Fully Integrated Practice." It's a group practice. So we are kind of back to where we started from.

(From the Audience): This is to any of the panelists. I want to put together some type of integrated group with anesthesiologist ObGYN's and [. . .], I didn't hear mentioned, is there a problem where if within a certain geographic area, we have 30%, 40%, 50% of physicians, and we start triggering attention that's going to get us?

JAY MARTUS: It's a good question in terms of antitrust. Yes and no. Obviously you would be on inquiry [notice] and you'd have to look at it. But you'd have to use some predatory practice. Because if you are a single integrated entity, you wouldn't have a combination in restraint of trade. So you would not have to worry about the first part of the Sherman Act. What you would have to worry about is the "rule of reason" analysis as to whether you were using that power or that leverage or that market power to unfairly raise the price, or value, or cost of those services over and above the fair market value. And we're not doing that and other people aren't doing that. If you look at the range of services which are being paid in other markets for similar services, we're lower than they are, and we're merely trying to get those dollars so that there's a lower amount of dollars kept on the profit side from the managed care companies. Instead of being at 25% margin maybe we can get it to a 7% or 8% margin.

MARC AUERBACH: Two points. One, I'm not necessarily convinced that there [are] antitrust cases out there even [saying that] even though you've reduced prices you may be colluding in the market place. — But, there are specific guidelines. The FTC and the Attorney General have come out with a whole — it was nine different fact patterns, now its up [to] 20 or 21, where they run a whole set of scenarios and there're safe harbors depending on the type of group you have, whether it's exclusive group or nonexclusive entry to the group. The first place I would start if I was putting together that type of group idea and I had antitrust concerns, I go read through those regulations and their safe harbors. They are pretty good, in terms of at least giving you, you know, general analysis. Each case obviously, you know, you have to analyze on it's own merits, — that's usually with respect to antitrust position. That's usually the starting point.

JAY MARTUS: The other issue is you have to really carefully look at and is very important [to understand] is the relevant market area. What are the alternatives that the payors have and the consumers have to obtain services? Because you may say that's within a 15 mile geographic area but what if five miles down the road — if there's an open alternative then it blows away any antitrust issue.

MARC AUERBACH: The trickier issue is if you're in a nonintegrated model, if you're not in that group practice model is the price-fixing issues. It's a much trickier issue when you have the IPAs and some of the non-integrated model when you have, ostensibly, competitors sitting in the room trying to determine, "Well how should we price our services for this managed care?" That's a lot trickier and there's all kinds of messenger models and fancy things that people put in to place to deal with price fixing issues, which I think is more complicated.

JAY MARTUS: That has led to the demise of IPAs, essentially.

JEFF COHEN: And as practical matter, I think most of us who deal on this kind of business find that putting together two or three physicians, let alone 20% or 30% of any relevant product market, relevant geographic market, it's a tough product to build.

MARC AUERBACH: Where you'll run into it is if you are in a highly specialized practice area. I was involved with a group of IBF physicians and you may be in a community where there are only two IBF physicians in the relevant geographical market place. When you start to get involved in super sub-specialties it may be some of the pediatrics super sub-specialties that may come up.

JEFF COHEN: Another thing I noticed is the compensation on the physician's side gets squeezed, physicians are fighting over parts of the body that they weren't fighting over before so all of a sudden the other alternative services that are available is increasing, that pool is increasing. So it becomes in some respects, and some areas actually less, a little more difficult to have the problems that we are talking about.

TIM RAVICH: Any more questions? A sincere thank you to our excellent panelists.

(Applause)

VIII. CONCLUDING REMARKS

[...]

EDITED TRANSCRIPT ENDED

