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PPMCs: A Perspective

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I. PPMC?

There has been a mad rush by Physician Practice Management Companies ("PPMCs") to leave the business. That makes sense in light of the lack of capital following the industry devaluation following the failed Medpartners/ PhyCor merger in January, 1998 and the adverse effect of the accounting changes mandated by the Emerging Issues Task Force of the SEC. Was it a bad idea for many sellers from the start though? What lessons should sellers take away from the latest fad to hit the physician practice industry?

II. THE PROMISE

In speaking about the PPMC business, it is important to focus on the most relevant point in its evolution. Early on, PPMCs experimented with several affiliation models in search of one that seemed to fit. They employed doctors directly in their own companies and, where permitted by applicable law, they bought medical practices (in both stock and asset purchases). The model most PPMCs ultimately settled on was the "management model." As such, with today's "Pure PPMCs," the two core agreements are an asset purchase agreement and a management services agreement.

One still has to be careful not to confuse "niche product" providers with PPMCs. Some providers of specialty care services (i.e., anesthesia, OB/GYN, neonatology) also get the "PPMC" brand, when in fact they are actually more

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like employers and group practices in the traditional sense. They may use stock power agreements, stock purchase option agreements and other "management looking" mechanisms, which give them the right to become the doctors' employers at the flick of a switch, but they are different because they are much more integrated and aligned with their doctors.

Though it is beyond the scope of this topic, suffice it to say that today's PPMCs and niche providers differ from each other in at least the following ways:

1. PPMCs attracted physicians by offering a purchase price and management ability, while niche providers attract physicians by giving them the security of employment. That is, PPMCs sold "independence," while the other sold a form of job security. Ironically, it is the delusion of independence which is at the heart of PPMC failures, since physicians never became fully aligned with the company;

2. PPMCs require long term arrangements (20-40 years), while niche providers limit their requirement to pay their doctors to an average of five years or base in on financial performance, typically EBIDTA measures; and

3. PPMCs are running for the hills, while niche providers are just running. Though niche providers have been hurt by the market's punishment of the entire health care industry, they seem to have remained committed to their core businesses.

The first PPMC representative a doctor usually met was a salesman. The salesman was very affable and described a relationship which seemed too good to be true, promising to:

1. Pay the doctor a lot of money for the doctor's assets, receivables and goodwill;
2. Save the doctor from administrative headaches;
3. Lower overhead through economies of scale;
4. Enhance the doctor's ability to get favorable managed care agreements and to attract new business;
5. Use the PPMC's money to develop ancillary services; and
6. To the extent the doctor will take stock in the PPMC, make the doctor rich through the stock's growth.

III. THE PURCHASE PRICE

When viewed closely, the first item is actually a revenue stream purchase. As described below, the PPMC's fee (the "management fee") was based on a percentage of the practice's revenues (gross or net). If you increased the purchase price, you had to increase the management fee, or vice versa. How much a revenue drop (management fee) the doctor would tolerate drove the purchase price.

Understanding this was elusive for many doctors but remains key for anyone working in or with the industry. Though a full understanding is beyond the scope of this article, one key point should be made: the purchase price (excluding the receivables and asset payment, if any) is simply the PPMC's prepayment of some amount of a practice's earnings. If, for instance, ten percent of a practice's earnings is $100K, the PPMC might pay four to eight times that amount at closing. Why ten percent? Because that is the agreed upon amount of the management fee. If, however, the PPMC paid the seller fifteen percent of the anticipated practice earnings, the management fee would be fifteen percent. The purchase price, in essence, is simply the prepayment of the portion of an anticipated revenue stream. In that respect, the management fee charged by the PPMC is not really a management fee at all. That is, it is not a fee payable by the practice for the management services provided by the PPMC. It is instead, the repayment of the purchase price, with a return factored in.

Here is another way to look at it. PPMCs simply prepaid the doctor (the purchase price) some portion of what the doctor would receive in compensation over a period of years. As such, doctors who entered into PPMC relationships received the value for instance of five years worth of reduced compensation at closing. If for instance a doctor who earned $100K each year was willing to forego $10K each year, he would get somewhere between $40K and $80K at closing as the purchase price. In return, his or her annual compensation would be reduced by $10K during the entire duration of the management services agreement (20-40 years).

The price was paid to the selling doctors through a combination of cash and stock. Some PPMCs issued notes in lieu of some or all of the cash or stock. The stock's vesting was generally delayed one year by SEC rules, and underwriters may have had additional lock up restrictions. The price of the stock at vesting is of course anyone's guess. Historical performance is often a good indicator though, and the 52 week performance report of some of the top PPMCs at the end of 1998 showed the devastation caused by Wall Street's disenchantment with the industry following collapse of the Medpartners/ PhyCor purchase. Even in the prior year, however, the stocks were clearly

volatile, but some were still receiving "Buy" or "Strong Buy" recommendations as late at the third quarter of 1997, making future stock value extremely difficult to predict:

	1997		1998	
Company	*High*	*Low*	*High*	*Low*
PhyCor	35.50	18.87	33.25	3.93
Medpartners	32.00	7.12	32.00	1.31
FPA Medical Management	40.00	14.87	40.00	0.06
PhyMatrix	17.00	11.00	16.50	1.93

Any notes were typically subordinated to senior lenders which had a perfected security interest in the PPMC assets. The seller's goal of course was to obtain adequate security for the PPMC obligation. Create a security interest for the doctor. Be sure the obligated parties are solvent and that there is adequate capital or assets to satisfy the obligation. Of course, the reality was often that the PPMC was fairly inflexible on these points and was controlled by the lenders.

The purchase price issue was often key for a selling doctor, particularly one who viewed the PPMC transaction as part of a retirement strategy. The seller understood, at least initially, that there would be a drop in revenues because of the management fee, but the doctor conceptually "booked" the entire purchase price and was persuaded by its time value. In short, the only sure thing, but the most persuasive thing, was the cash paid at closing.

As for buying the accounts receivable, sellers had difficulty with the fact that the payment would be charged back to the practice or would be handled as part of the reconciliation or due to/due from. The asset purchase proved, however, to be a relatively insignificant issue since only the practice accountants saw the effect of passing the opportunity to depreciate the assets on to the PPMC. Practically speaking, the A/R issue is more significant in unwinding these transactions, since they tend to have been very degraded.

IV. MANAGEMENT

Selling doctors were typically faced with one of two situations: the company had management infrastructure or was going to purchase it after going public. For those that had the infrastructure, it was easy enough to check on the backgrounds of the personnel and to find out about the systems in place. For those that were going to buy it after going public, it was a leap

of faith. Regardless, however, the notion generally conflicts with another PPMC selling point: seamless independence.

Most PPMCs sold the idea that the transition to a PPMC-run practice would be fairly seamless and would preserve local physician control. "Your staff will stay, but will become our employees. We will never do anything you do not agree to. Everything will remain the same," many sellers were told. If, however, the seller was trying to solve a management problem, why would they want everything to remain the same? Though it is true that many PPMCs tried to increase the sophistication of practices through information systems, they generally lacked the personnel to run them or to produce useful information.

V. OVERHEAD REDUCTION

This issue also ran up against the "seamless independence" promise. PPMC attempts to reduce overhead through changes in physician behavior or reduction in staff or benefits proved to be extremely difficult, so overhead reduction efforts have been largely limited to group purchasing discounts. When offset by the increase costs of sophistication through costlier management and information systems, net overhead reduction has also proved elusive.

VI. ENHANCED CONTRACTING

Physicians joining PPMCs often agreed with PPMC claims that there would be safety in numbers. Many PPMCs seem not to have fully appreciated antitrust restrictions or to have considered business realities. For the Pure PPMC, a management model with competing medical practices in the same market simply does not create sufficient economic integration necessary for effective joint contracting. This is nothing new. Unfortunately for the PPMCs and the doctors, there have been relatively few meaningful changes since Southbank IPA in 1989. Moreover, even the *Statements of Antitrust Enforcement Policy in Health Care*, issued August 28, 1996 have done little to alleviate the longstanding antitrust restrictions. At the end of the day, PPMCs are usually left with a Messenger Model for contracting purposes, an unexciting and ineffective mode of contracting.

From a business perspective, in a market of heavy managed care penetration like many metropolitan areas of Florida, it would take a lot of market power to improve a physician's contracting position. In such areas, there are often so many competing doctors that, even ignoring the antitrust restrictions, it is probably impractical for a PPMC to coalesce a large enough contracting group, except perhaps in distinct geographic pods.

Attracting new business is tied to the PPMC's ability to create an effective managed care contracting organization; but there is a direct relationship between being left out of a closed panel and the ability to enter the panel on becoming part of the contracting organization which participates. Though it is undoubtedly an issue for many specialists whose contracting opportunities are limited by closed panel networks, the issue seems to be on the wane because of payer response to point of service product demand, direct access legislative changes and geographic coverage issues.

VII. ANCILLARY SERVICE DEVELOPMENT

Where the concept does not involve "designated health services," it becomes purely an issue of economic analysis. What is the cost of development? Is there sufficient volume to support the service? Will managed care direct patient referrals to the service out of the practice? The surprise for many doctors in PPMC relationships arose in their failure to understand the "fine print" and health care regulations. In particular, many doctors were surprised to learn that they would be carrying all of the costs of developing ancillary services, including paying the cost of the capital loaned by the PPMC.

Squaring the development goals of the practice with state and federal self referral restrictions has also proven to be vexing. The "group practice" restrictions in particular compel both integration and size in order to be economically viable, both of which have proven to be difficult to achieve.

VIII. WHAT MOTIVATED THE PPMCS

Why would a PPMC enter into this type of transaction? The core of the answer is that Wall Street investors placed a huge value on PPMC practices which grossly exceeded what the PPMC paid for them. Why? Because Wall Street typically invests in the future earnings of a business, not on its current value. If one could pay $10K for a car, then sell it for $100K, that would be a windfall for the seller. That type of arbitrage was compelling to PPMCs, and investors lined up with a lot of money to invest in the industry. The investors liked the fact that the management relationships were long term (20 to 40 years). They enjoyed the accounting benefits resulting from 40 year amortization; and were persuaded by the fact that many agreements contained additional income opportunities for cost savings and for the development of new services. That was the golden age of the industry.

Though it was very significant, arbitrage was only one piece of the puzzle. As with any start up business, the debt a PPMC acquires early in its existence is far more expensive than the debt it takes on once it proves itself. Venture

capitalists, for instance, commonly expect a return on their investment of 40-50% because they are betting on a generally unproven business. To prove itself, a PPMC had to do one thing: grow. And PPMC growth required a lot of money. Once a PPMC grew out of being a small cap company (under $100 Million) institutional investors, which generally expect a return of only 10-20%, could be expected to invest in the company. Hence, the dynamics of the industry itself created an inherently dangerous cycle of taking on debt to grow the company and replacing expensive debt with cheaper debt (but only if the company continued to grow). Unfortunately, since the market shift following the Medpartners/PhyCor failure and the EITF changes, a new cycle is crushing the industry, the investors and the sellers: stagnate because of lack of capital from falling stock prices, drown under debt load, cut overhead, provide no services to sellers, and wait for lawsuits to be filed.

IX. THE LESSONS

Perhaps one of the most difficult parts of the PPMC experience is that PPMCs were not sufficiently incentivized to deliver the services sellers thought they were to receive. Even more sophisticated physicians who understood the revenue stream aspect of the transaction believed in enhanced same store performance. After all, many PPMCs had an economic incentive to save the practice money and to grow the practice, as most received a piece of the savings and the growth on top of the management fee.

Nevertheless, there is something insidious about the PPMC business model itself, which necessarily leads to the issue of the need for regulation. The fact that the model went as far as it did and that it involved an essential service like physician services is disturbing. Medical business is not a normal service; it is an essential service. Why did the SEC permit outrageous values to be set for the companies? Why did the State or federal regulators not take a close and meaningful look at the effect of the business on health care before enabling it so? This is beyond the scope of this article, but the questions remain because the adverse affect of the industry bottoming out may threaten not only medical business but patient care as well.

Finally, physicians have to bear some of the responsibility. Frankly, some of the promises made by the industry required a huge leap of faith. What advice was obtained? Was it followed? If the PPMC was so committed to enhancing bottom line performance of the practice, why did sellers not require the PPMC to commit to this obligation in writing, and why are there generally no disincentives in the management services agreements (MSAs) for a PPMC's failure to perform? The MSAs commonly contain empty language of intent, and this should never have been tolerated. Additionally, physicians should refuse to believe that they can own a business without administrative

headaches, and they should shut their ears to anyone offering them a "magic pill." Physicians generally have two choices today: be in business and bear the risks and rewards that being in business offers or become employed by someone or something that will relieve them of the risks, the headaches and, at least to some degree, the rewards.

Physicians and business people need to understand why the ground was fertile for PPMCs. PPMCs, like PHOs and IPAs, are all borne out of the need for physicians to integrate to survive in markets of shrinking reimbursement. However, PPMCs and other passe models of physician integration have failed or proven only partly valuable because they are premised on the delusion that the benefits of true integration could be obtained without actually integrating. Though PPMCs are just one point in what promises to be a long line of businesses formed in response to the financial pressures doctors face, it is probably safe to say that the only survivable business model for physicians will have the following characteristics:

1. It will have effective and sophisticated mechanisms in place to relieve the doctor from administrative headaches;
2. It will lower overhead through economies of scale;
3. It will enhance the doctor's ability to get favorable managed care agreements and to attract new business;
4. It will involve access to capital to be used for economically rational development; and
5. It will align the incentives of the doctors with the business itself.