The Evolution of Physician Practice Management: Past Missteps and Future Trends Pre-Conference Workshop

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Evolution of Physician Practice Management: Past Missteps and Future Trends
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PPMC Timeline

• 1991 - PHP Healthcare becomes the first physician practice management company to go public
• 1997 - 34 public companies raised $2B
• 1998 - Sherlock & Co. estimated 39 public PPCMs and 125 private.
• However, PPCMs hit financial difficulties and started filing for bankruptcies
• By June 1999, public PPCMs fell to 22 companies
• Just five left today, including one that’s being taken private and one veterinary practice manager
## Public PPMCs

### Physician Groups
- Advanced Health Corp
- American Oncology Resources
- American Physician Partners
- BMJ Medical Management
- Concentra Managed Care
- EmCare
- FPA Medical
- MedPartners
- Omega Health Systems
- Pacific Physician Services
- Pediatrix Medical Group
- PHP Healthcare
- PhyCor
- PhyMatrix
- Physician Reliance Network
- Physicians Resource Group
- Physician Specialty Corp
- ProMedco
- Response Oncology
- Sheridan Healthcare
- Specialty Care Network
- Team Health

### Dental Groups
- American Dental Partners
- Apple Orthodontix
- Birner Dental Management Services
- Castle Dental Centers
- Coast Dental Centers
- Dental Care Alliance
- Gentle Dental Service Corp
- Monarch Dental Corp
- OrthAlliance
- Orthodontic Centers of America
- Pentegra Dental Group
Investment Rationale (back then)

- Physicians: Good at medicine, not at business
- Professional management enhances efficiency
- Negotiating leverage with managed care contracting
- Focus on office-based practices
- Purchasers: Investor-owned companies, private equity
Healthcare Spending % of GDP, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Per Capita Spending on Healthcare, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Health Care Expenditure per Capita by Source of Funding, 2007
Adjusted for Differences in Cost of Living

<table>
<thead>
<tr>
<th>Country</th>
<th>Out-of-pocket spending</th>
<th>Private spending</th>
<th>Public spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>890</td>
<td>3,092</td>
<td>3,307</td>
</tr>
<tr>
<td>NOR</td>
<td>720</td>
<td>4,055</td>
<td>2,618</td>
</tr>
<tr>
<td>SWITZ</td>
<td>449</td>
<td>1,360</td>
<td>2,726</td>
</tr>
<tr>
<td>CAN</td>
<td>580</td>
<td>589</td>
<td>2,844</td>
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<tr>
<td>FR</td>
<td>246</td>
<td>510</td>
<td>2,758</td>
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<tr>
<td>GER</td>
<td>470</td>
<td>360</td>
<td>2,716</td>
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<tr>
<td>SWE</td>
<td>528</td>
<td>79</td>
<td>2,124</td>
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<tr>
<td>AUS*</td>
<td>671</td>
<td>441</td>
<td>2,046</td>
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<tr>
<td>UK</td>
<td>343</td>
<td>204</td>
<td>2,446</td>
</tr>
<tr>
<td>ITA</td>
<td>542</td>
<td>88</td>
<td>2,058</td>
</tr>
</tbody>
</table>

* 2006
Source: OECD Health Data 2009 (June 2009).
Source: Organisation for Economic Co-operation and Development (OECD)
Government % of Healthcare Spending, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Per Capita Spending on Hospitals, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Acute Care Beds per 1,000 Population, 2007

Source: Organisation for Economic Co-operation and Development (OECD)
Hospital Discharges per 1000 Population, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Physician Practice Management

Hospital % of Total Healthcare Spending, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Per Capita Spending on Pharmaceuticals, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Pharmaceutical % of Total Healthcare Spending, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Physician Practice Management

Physicians per 1,000 Population, 2008

Source: Organisation for Economic Co-operation and Development (OECD)
Average Annual Number of Physician Visits per Capita, 2007

<table>
<thead>
<tr>
<th>Country</th>
<th>Visits/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>GER</td>
<td>7.5</td>
</tr>
<tr>
<td>ITA</td>
<td>7.0</td>
</tr>
<tr>
<td>AUS</td>
<td>6.3</td>
</tr>
<tr>
<td>FR</td>
<td>6.3</td>
</tr>
<tr>
<td>OECD Median</td>
<td>6.3</td>
</tr>
<tr>
<td>CAN</td>
<td>5.8</td>
</tr>
<tr>
<td>NETH</td>
<td>5.7</td>
</tr>
<tr>
<td>UK</td>
<td>5.0</td>
</tr>
<tr>
<td>NZ</td>
<td>4.7</td>
</tr>
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<td>SWITZ</td>
<td>4.0</td>
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<tr>
<td>US</td>
<td>3.8</td>
</tr>
<tr>
<td>SWE</td>
<td>2.8</td>
</tr>
</tbody>
</table>

* 2006
** 2005

Source: OECD Health Data 2009 (June 2009).
Physicians and the Affordable Care Act

• Extends coverage to the uninsured, increasing demand for primary care services
• Seeks to change pay differential between primary care and specialties through extra payments, funding for training
• New concepts: ACOs, site-neutral payments, bundling
• Much uncertainty, other that there’ll be unintended consequences
Physician Practice Management

Social Security and Expected* Medicare Benefits and Taxes for Average-Wage, Two-Earner Couple ($43.5k each)

<table>
<thead>
<tr>
<th>Year Cohort Turns 65</th>
<th>Social Security Benefits</th>
<th>Medicare Benefits</th>
<th>Social Security Taxes</th>
<th>Medicare Taxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>$297,000</td>
<td>$36,000</td>
<td>$595,000</td>
<td>$209,000</td>
</tr>
<tr>
<td>2010</td>
<td>$906,000</td>
<td></td>
<td></td>
<td>$704,000</td>
</tr>
<tr>
<td>2030</td>
<td></td>
<td>$1,226,000</td>
<td>$971,000</td>
<td></td>
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</table>

* Expected rather than realized benefits. Notes: The “average” wage profiles are those hypothetical profiles used by the Social Security Administration in its analyses. Lifetime amounts are rounded and discounted to present value at age 65 using a 2 percent real interest rate and adjusted for mortality. Projections based on intermediate assumptions of the 2011 OASDI and HI/SMI Trustees Reports. Medicare benefits are net of premiums. Includes Medicare Part D. Source: Stephanie Rennane and C. Eugene Steuerle, 2011. Based on earlier work with Adam Carasso.

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Investment Rationale Today

- Physicians: Good at medicine, not at business but burdened by administration
- Professional management enhances efficiency, tracks and reports quality and costs
- Negotiating leverage with managed care for contracting collections
- Focus on office-based referring practices and hospital-based services
- Purchasers: Investor-owned companies, private equity and hospitals
- Source of capital
- ACOs/Bundling/Site-Neutral Payments: Safety in numbers
Recent Capital Markets Transactions
Publicly Traded Companies

IPC The Hospitalist Company
IPO
2008
MEDNAX
Changes name from Pediatrix Medical

Team Health Holdings
IPO
2009

American Dental Partners
Taken Private
2012
Emergency Medical Services Corp
Taken Private

2010
2011
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Outperform / Buy 62% Outperform / Buy 14%
Market Perform / Hold 35% Market Perform / Hold 8%
Underperform / Sell 1% Underperform / Sell 50%
Not Rated 3% Not Rated 0%

For purposes of the NYSE and NASDAQ, rating distribution disclosure requirements, our rating of Outperform, Market Perform and Underperform closely correspond to Buy, Hold and Sell, respectively.

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The Perception of Physicians: Yesterday and Today
Lessons of the 1980s

- Many of the predictions did not come true
- Organizations made deals with physicians that were not financially sound
- Physicians were employed without business justification
Current Market Trends and Realities

▪ Growing physician shortages – demand chasing supply
▪ Lifestyle and economics deteriorating for many physicians
▪ Private practice & solo and small groups threatened
▪ Growth of larger medical groups
▪ Physician utilization of hospitals changing
▪ Hospital needs/expectations of physicians going up
▪ Generational needs/wants in conflict
  – Current economic environment has slowed physician retirements
  – New physicians will want to work fewer hours
▪ Independent Medical Staff Structures struggling
▪ Patient service expectations are evolving
Effect of Health Care Reform on Physician Economics

- Substantial Medicare cuts
- Health reform emphasis on reducing premiums, leading to reduced payments to providers
- Shift of $ from specialists to primary care
- Higher practice costs:
  - Health Information Technology ("HIT")
  - Quality data reporting
  - Increased regulation
- Shifting payment from FFS to bundled, capitated, and shared savings payments involving broader swath of the care continuum
Hospital-Physician Alignment
Hospital-physician alignment strategies focused on the “brave new world” of health care delivery and payment reform

- Shift from volume-based payment models to value-based payment models will change hospitals’ and physicians’ financial incentives, and how they will deal with one another

- Emerging payment reward, effective clinical and financial integration between hospitals and physicians across the continuum of care, and penalize those who do not adapt
Physician Alignment Goals and Objectives

- Patient Access
- Clinical Quality
- Service Line Growth
- Geographic Expansion
- Managed Care contracting
- Competitive Threats
- Clinical Integration
Physician Integration/Alignment Strategy

▪ Development of integrated self-governing group practices with oversight from the health system
  – Professional autonomy
  – Support, oversight and infrastructure of the health system

▪ Key Components
  – Strong physician leadership
  – Development of a group practice culture
  – Communication
  – Supportive compensation strategy
Redefining The Care Delivery Model

Insanity: Doing the same thing over and over again and expecting different results.
Albert Einstein
Where Is The Market Going ...

▪ Patient-centered care
▪ Slowing the rate of cost growth
▪ What will be rewarded
  – Quality
  – Outcomes
  – Safety
  – Efficiencies
The Triple Aim Journey
(Institute for Healthcare Improvement):

- Improve the health of the population
  - Encourage better health for entire populations by addressing underlying causes of poor health, such as physical inactivity, behavioral risk factors, lack of preventive care and poor nutrition

- Enhance the patient experience of care
  - Improve individual patient experiences of care along the IOM 6 domains of Quality: Safety, Effectiveness, Patient-centeredness, Timeliness, Efficiency, and Equity

- Reduce, or at least control, the per capita cost of care
  - Lower the total cost of care resulting in reduced monthly expenditures for Private Pay, Medicare, Medicaid or CHIP beneficiaries improving care

Source: http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm
We Haven’t Been There, We Haven’t Done That

- Performance Risk (based on what is done to mitigate diseases, a function of the numbers and types of treatments that are applied)
- Population of patients
- Rational Allocation of Revenue
- Value Based
- Care Coordination
- Pay for quality
- Patient-centric focused
- Physician leadership
- Do less
- Prevention
Concierge Medicine for the Masses – The Medical Home

- A personal physician, directly accountable to the patient for the full range of care, rather than being a gatekeeper, leverages the resources of the medical home to coordinate and facilitate the care of patients . . . advocating for and providing guidance to patients and their families as they negotiate the health care system

- Goals and Objectives
  - the right care, at the right time, in the most appropriate setting
  - minimize overtreatment or under-treatment and efficiently allocate resources while improving the overall quality of care
  - guided by evidence-based medicine
  - enhanced access to care
The Starting Point - FMV

NO... IT CAN'T BE... NOT FAIR MARKET VALUE!
Why Fair Market Value Matters

- Historically, viewed as “soft” requirement
- Key concept in Federal Anti-kickback Law
- Key element in Stark Law “Physician Employment” exception
  - Under the Stark Law, the defendant has the burden of proof that an arrangement is fair market value
- Unlike technical elements or “structural” violations, requires fact-based inquiry
- Increasing source of government inquiry and *qui tam* lawsuits

Reputational risk
Commercial Reasonableness Guidelines

- The test for commercial reasonableness is separate from the assessment of FMV
  - FMV applies to the level of compensation for the physician’s services
  - Commercial reasonableness applies to broader business issues related to the arrangement
    - This is especially important in arrangements that include compensation for administrative and other non-clinical services
Commercial Reasonableness Guidelines

- The agreements or other documentation should attest to the existence of relevant commercial reasonableness factors:
  - The services covered by the arrangement are *essential to the operation of the organization and/or addressing the community’s unmet needs* and are fully defined in the form of a job description or similar document.
  - There is a *sound business reason/need to pay* for the services and the services to be provided require that a licensed physician perform the services:
    - If applicable to the situation, the services require a physician from a specific specialty.
  - The number of physicians assigned to perform the services is appropriate.
  - The physician is *actually providing the designated services* as evidenced by documented work product, time logs/records and periodic performance reviews.
It Is Going To Be All About “Quality”
What To Be – How To Be

▪ What To Be: A tightly coupled organization
  – Shared destiny
  – Organized around a clear mission
  – Driven by common values
  – Clean and unified vision of the future

▪ How to Be: Management of expectations - this does not happen overnight
  – A well designed foundation
  – A shared destiny and assumed accountability
  – Shared decision making
  – Sound business modeling

Meaningful participation in strategic and operational decision making
The Concluding Thought

For hospitals/health systems evaluating physician employment opportunities and arrangement, the key question is:

*How will the strategy/structure/transaction bend the cost curve and raise the quality bar?*
Questions

▪ What are the key drivers fostering consolidations and acquisitions among physician practices? How are these drivers reflected in public market appetite for PPM Cos?
Questions

- Why is this wave of acquisitions/consolidations different from the experiences of 20 (or even 10) years ago? Is this phase of consolidation any more likely to succeed?
Questions

▪ What are the primary operational and financial strategies being employed by acquirers in executing acquisition/consolidation plans? Is there an ideal size or configuration to a physician practice consolidation? What works and what doesn't?
Questions

▪ What are the key "side effects" (i.e., setbacks) that have been experienced in this phase of consolidation, and how are consolidators responding?
Questions

▪ How does the SGR problem (i.e., Medicare "Doctor Fix") -- current state and prospects for resolution -- affect the calculus of practice acquisitions?
Questions

▪ How will the success or failure of PPACA affect the current pace, character and valuation of practice consolidation/acquisitions?