

## **Physician Network Development Alternatives**

*Cash Purchases Aren't the Only Way – And May Not Be the Best Way –  
To Develop a Primary Care Physician (PCP) Network, June 3, 1998 Healthcare  
Review*

By Ronald Adams

For some time now, hospital health systems (the “system”) have sought new sources of revenue, expanded geographic market share, referral streams and greater managed care contracting clout by developing or expanding their own primary care physician (PCP) networks. While vast amounts of money have been invested in such purchases, the returns have often been disappointing. The initial acquisition requires a great deal of up-front capital (for the both the acquisition cost and working capital investment); the subsequent management of the network needs further commitments in money, time and managerial expertise. Worse, the two to three year income guarantees that many physicians demand provide a powerful disincentive to continued productivity, denying the health system the very efficiencies and returns on investment it had hoped to achieve by creating the network.

If health systems are to enjoy the benefits of network development, they must be more sophisticated in the way they structure the networks themselves. After carefully reviewing their own capital resources, their capacity to carry financial risk and the degree of management responsibility they wish to hold, health systems have several alternatives to consider. While the following approaches have different structures, they do share some common objectives: to attract quality PCPs into the network at the lowest possible capital cost and lowest (if any) operating subsidies; to ensure that invested dollars do not “walk”; to provide a means to incorporate the PCPs’ covered lives into the system’s managed care contracts; and to permit other affiliation activities with the practices.

### **Practice Acquisition and Employment with Profitability Based Compensation**

Like the traditional acquisition, this model involves an outright asset purchase of the practice at fair market value, determined through an independent valuation that takes into account the practice’s tangible and intangible assets, financial trends, overhead, managed care participation and potential for growth. The physician typically retains the practice’s cash and accounts receivable and liquidates its liabilities.

The system manages all aspects of the practice including operations, billing and collections, managed care contracting, marketing, administration and human resources.

Unlike the traditional purchase, however, a productivity and or profitability-based compensation plan is built into the physician employment contract. For the first year, the physicians receive compensation based on a substantial percentage of their previous year’s income – with an incentive bonus based on productivity and practice profitability. After the initial “grace period,” physicians share the system’s financial risk, with compensation based on system-wide profitability; and their compensation directly tied to their own productivity. In addition, as the system funds growth, such as new physicians, infrastructure or new office sites, the practice incurs a “capital charge” to provide a favorable return on the system’s investment.

Of the network options, the acquisition offers the system the greatest amount of direct control – at a considerable expense in up-front capital and time-consuming management involvement. Aside from deep pockets, the system considering

acquisition must believe that it can control the delivery of healthcare more effectively than physicians left to their own devices – and should be equipped with the management tools, such as information systems, disease management programs, practice guidelines and utilization protocols, to support that belief.

### **Minority Investment Strategies**

In lieu of complete ownership and control, the system may opt for a compromise by acquiring a minority interest, up to 49%, in the practice. Under this arrangement, the practice enters into a long term affiliation through which the practice participates in all current and future health system managed care risk contracts the system offers. The practice, however, is not obligated to purchase management support services such as operations support and billing and collection. To protect the minority investor from domination by majority shareholders, certain key actions of the board, such as the distribution of earnings and the termination or renewal of management contracts, require super-majority approval.

In exchange for the reduced investment in capital, the health system accepts a loss of direct control.

The minority investment approach may be attractive to many physicians: not only do they retain the clinical control they value, they may welcome the system's investment as an opportunity to improve their practice infrastructure or to facilitate growth.

If the system wants to expand or develop in a geographic area without physician group practices of any appreciable size, it may want to employ a "roll-up" strategy. In this approach, the system coordinates and funds the consolidation of several small or solo practices into a group practice large enough to facilitate a minority investment. The individual practices determine the merged practice's compensation and management structure, and the system acquires up to 49% interest at the time of the merger. The network then proceeds as an ordinary minority investment structure.

### **Affiliation Agreement Transactions**

At the opposite extreme from acquisition is the affiliation agreement. In a typical arrangement, the target practice cedes its risk contracting rights to the health system in return for some negotiated up-front financial consideration (physicians who wish to remain independent – and retain the right to contract with other health systems or network organizations – would not be "locked in" and would not receive any up-front consideration for their participation). The financial consideration is based on the practice's existing number of HMO patients, an analysis of the practice's historical managed care performance and the health system's budget for its risk contracts. Additional terms provide for the system's right of first refusal should the practice entertain a purchase offer.

While the affiliation agreement limits the system's control to those provisions specifically stated within the risk contracts, the arrangement can be structured quickly and with little money. In some cases, especially in rural areas, the affiliation agreement may be the best way a system can reach disparate, independent-minded physicians while building the negotiating clout the system needs to strike favorable contracts with MCOs and insurers.

## **Considering the Options**

When selecting a means for developing a primary care physician network, the

health system faces a conflict between the desire to conserve cash and the desire to control healthcare delivery: the more cash the system is willing to invest, the greater the amount of control it is likely to receive.

Yet capital may not be the most important consideration. Even those systems with large amounts of cash on hand (or the capacity to carry large amounts of debt) may not *want* the control acquisition provides. In many cases, physicians are willing and prepared to manage themselves, and the additional intrusion of system management may not only be unwelcome, it could be downright counterproductive. For the system proceeding with a plan for network development, it is just as important, if not more so, to analyze the merits of the management structures, as well as the financial underpinnings. In the not-so-long run, the management process may prove more vital to the system's health.

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