

PA 518 Assignment

Select one of the cases below, read the case very carefully then answer the questions for the case as they apply to the materials and topics discussed in this course.

Case Study One

Physician Practice Management Companies and PhyCor, Inc.

Physician practice management (PPM) firms grew rapidly in the late 1980s and early 1990s. PPMs promised to infuse physician practices with needed capital and provide significant cost savings and increased revenues through economies of scale and improved management. They also promised to allow physicians to negotiate better contracts with the emerging HMOs and PPOs. However, by the end of the century, all of the major PPMs had gone out of business or significantly downsized to the point where their valuations were a tiny fraction of their prior capitalization. Some, such as Med Partners, declared bankruptcy. Others saw their valuation plummet to almost zero. What went wrong? This case examines the history of PPMs and the story of PhyCor, Inc., one of the prominent players in this drama.

PPMs were created in response to a lack of retained earnings and marginal management in many physician practices and the growth of HMOs and PPOs. As a result of increased managed care, physician organizations/ medical groups experienced increased costs and lower net revenues. HMOs and PPOs also demanded large discounts from physicians. Furthermore, physician practices needed capital to buy out senior partners, install information systems, and change their structures and governance. PPMs backed by significant venture capital were better able to meet physicians' needs. They purchased prestigious medical groups, consolidated independent practices, and acquired physician clinics that were being divested by HMOs. By the early 1990s, consolidation had created three prominent companies.

Many of the physician practices signed 30- to 40-year management services contracts with the PPMs. Usually these contracts specified that physicians would receive a split of revenues after payment of clinic expenses. The lower cost of capital, centralized purchasing, and greater bargaining leverage with insurer organizations would lower costs and increase revenues.

PhyCor was incorporated in 1988. By 1995 it had become a medical network management company that managed multispecialty medical clinics and other physician organizations, provided contract management services to physician networks owned by health systems, and developed and managed independent practice associations (IPAs).¹ The company also provided healthcare decision support services, including demand management and disease management services, to managed care organizations, healthcare providers, employers, and other group associations.

At its affiliated clinics, PhyCor implemented a number of programs and services to promote growth and efficiency, including strategic planning and budgeting that focused on revenue enhancement, cost containment, and expense reduction, among other areas. The company negotiated managed care contracts; entered into national purchasing agreements; conducted productivity, procedure-coding, and charge-capturing studies; and assisted the clinics in physician recruitment efforts. It maintained information processing systems that expanded the clinics' accounting, billing, receivables management, scheduling, and reporting systems' capabilities. The company initiated improvement projects designed to enhance the quality of patient service delivery systems at its affiliated clinics through the maintenance and measurement of performance standards and collection and review of patient evaluations. In addition, it provided operational support through a better practices resource group, which focused on helping clinics (or departments within clinics) increase their patient services revenue and expense savings. Under the terms of existing service agreements, the company typically provided equipment and facilities for each physician group, managed clinic operations, employed the clinics' non-physician personnel (other than certain diagnostic technicians), provided capital for expenditures, and received a service fee equal to the clinic expenses it had paid plus a percentage of each clinic's operating income (net clinic revenue less certain contractually agreed-upon clinic expenses before physician distributions) plus—in some cases—a percentage of net clinic revenue.

PhyCor, which called itself the "physicians' corporation," had come a long way in six years. Its revenue had soared from \$1.2 million in 1988 to \$136 million in 1992 to \$240 million in 1994. In 1992 it ranked fifth in Fortune's list of rapidly growing public companies. The company's long-range goal was to have clinics across the United States.

In 1994 the company owned 22 group practices, which employed almost 1,200 doctors in 15 states. In 1997, following its disclosure of the difficulty it was having integrating some of its smaller physician practices into bigger groups; the company's stock price plummeted. Between September 1997 and September 1998, Wall Street's valuation of the 15 largest PPM firms fell by 64 percent, while the PPM industry as a whole lost as much as half of its commercial value.

PhyCor was undeterred and wanted to take advantage of market conditions to gain a competitive advantage. It offered \$8 billion in stock and debt to buy its much larger competitor, Med Partners Inc., in October 1997. PhyCor's shares fell by more than 10 percent after the deal was unveiled, while Med Partners stock fell further (by 45 percent). Shortly thereafter, PhyCor scuttled its planned purchase of Med Partners Inc., blaming differences between the companies on how to manage physicians' practices. In December 1997, PhyCor announced that it had signed an agreement to purchase Seattle-based Care Wise, Inc., a nationally recognized leader in the healthcare decision support industry. In May 1998, PhyCor acquired Ontario-based Prime Care International Inc. The 2,200 general practice and specialty physicians under Prime Care's management and its Desert Valley Medical Center became part of PhyCor's 20,000-plus physicians and 61 clinics in 29 states.

Later that same year, PhyCor—citing industry turmoil—announced that it would not buy any clinics through 1999. This plan was a dramatic strategic turn for PhyCor. The company revised its earnings estimates downward for the second half of 1998. PhyCor and other PPM companies were plagued by earnings shortfalls, plummeting stock values, and reports of dissatisfied physicians. PPM companies struggled with declining Medicare rates and an inability to continue growing earnings through acquisitions. They also had relied too heavily on capitation—a method of payment for services in which doctors/hospitals are paid a fixed amount for each patient—and were earning insufficient revenues as a result. PhyCor stock was down about 74 percent in 1999. The company sold eight clinics during the fourth quarter to generate cash and downsize, retaining only clinics that were stable and had the potential to grow. PhyCor's earnings dropped sharply in the last quarter as well as overall for the year when it shut down several of its clinics. J. C. Hutts, chairman and CEO of the company, commented, "While we are disappointed by the loss reported in the first quarter, our EBITDA² was consistent with our early pronouncements. Our focus this year at PhyCor is to maximize our cash flow. We have identified several assets that we regard as nonstrategic and have begun a process to sell these assets for cash."

PhyCor—which then operated about 48 medical groups employing 3,076 physicians in 23 states and managed IPAs totaling nearly 25,000 physicians—restructured or terminated service agreements with nearly all of its multispecialty clinics across the country as it attempted to improve its ailing financial situation. Management contacted most of PhyCor's 27 clinics to discuss physician groups' repurchase of their clinic assets from PhyCor in connection with the restructuring or termination of their service agreements. Proceeds from the sale of these assets were used to retire outstanding debt. The company reported a net loss of \$452 million, compared to net earnings of \$3.7 million during the same period a year earlier. Analysts said that PhyCor had paid too much for clinics in some markets—these facilities wound up producing too little revenue—and that it suffered from lower reimbursement payments from insurers. As a result of the charges, the company no longer satisfied the minimum net tangible asset listing requirements of the NASDAQ Stock Market and was delisted.

Notes

1. IPAs are networks of independent physicians who contract together to provide medical services to individuals whose healthcare costs are covered by HMOs, other insurers, employers, or other third-party payers of healthcare services.
2. Earnings before interest, taxes, depreciation, and amortization.

Questions

1. What was PhyCor's initial strategy and business model?
2. What do you think went wrong with this strategy and business model?
3. Did PhyCor expand too rapidly? What benefits should the company have obtained from expansion? What occurred? Why?
4. Was the creation of the physician management companies a form of diversification because most of the leading companies' leaders came from hospital management backgrounds?

Case Study Two

St. John's reengineering

St. John's Hospital, a medium-sized hospital located in Seattle, Washington, was established in 1894 with a primary mission of caring for the sick and downtrodden. The hospital had grown and developed as a solo facility until 2000, when it merged with a suburban hospital, St. Agnes. This merger caused many changes in the organizational structure of both hospitals. A corporate office was established and located approximately halfway between the facilities. The president of St. John's, Jeff Jacobs, was promoted to the position of corporate president, and the president of St. Agnes became the senior vice-president.

The early 2000s was a busy time for the corporate office. By 2002 it had 45 employees. The hospitals diversified their organization by purchasing a number of urgent care centers, physician office practices, and skilled nursing facilities. Jacobs was certain that integration would create stability and financial success. However, the urgent care centers and the skilled nursing facilities barely broke even, and the physician office practices lost almost half a million dollars per year. As the years progressed, it became increasingly critical for the hospitals to generate enough cash flow and profit to subsidize the other parts of the corporation.

Both hospitals did reasonably well in the early 2000s, but with reductions in Medicaid and Medicare reimbursements, their margins narrowed. By 2003 both hospitals were earning less than a 2 percent net profit margin, and the prospects for 2004 seemed worse. 2003 was the first year patient revenues did not cover expenses. After seeing these figures, Jacobs called an emergency executive session. Those in attendance included the presidents of both hospitals, Jacobs, and corporate legal counsel. The only item on the agenda was to figure out what to do to get back into the black.

The first to speak was Joe Alexander, who at that point had served as corporate counsel for four years. He had been a staunch promoter of total quality management (TQM) since it had been introduced in 1993. However, because the system had not prospered recently, he and many others had become discouraged with the principles of TQM. Something stronger was needed to reenergize the hospitals and corporation. A few weeks prior to the meeting, Alexander was pondering this dilemma as he opened the afternoon mail. Among his many letters, a bright mailer caught his eye. It was an invitation to a local seminar on hospital reengineering. He had read material about reengineering in Fortune and other popular magazines and knew that prominent companies like Taco Bell and AT&T claimed they had experienced huge improvements as a result of their reengineering efforts. The local seminar cost only \$250, so he decided to attend. He finished the seminar the day before the emergency executive session.

"I just came back from a seminar that may be the ticket to save our hides," said Alexander. "Reengineering has been widely used in many industries to radically improve firms' costs, quality, and speed. I wish we had learned more about this opportunity earlier; we might not have wasted so much time on TQM."

“Tell us more about it,” said Jacobs.

“Well, it is a way to improve processes. Everything we do in an organization involves processes. Reengineering involves designing and implementing the most efficient, needed processes. It dramatically lowers costs—some say as much as 30 percent—and improves quality.”

Additional discussion ensued, during which the decision was reached to put Alexander in charge of an effort to reengineer both hospitals.

With great enthusiasm, Alexander took the corporate CFO, Mac, to another conference to learn how to implement this great process innovation. They wanted to be thorough, so they worked with an external consulting firm and developed a series of principles on which to focus. Alexander presented them to Jacobs for approval.

Alexander stated, “Thank you for the opportunity to develop this process. I think with our team and these guiding principles we can really reduce our costs and strategically position ourselves for competitive advantage.”

Jacobs asked, “Tell me again the seven principles you developed.” Alexander responded:

1. “Process-oriented organization;
2. Benchmarks set as achievement goals;
3. Blank sheets (biases were too strong among established people);
4. Standardization between the hospitals;
5. Employee-led teams—most efficient structure (reduces the need for mid-managers);
6. Three key areas of focus: access, materials, and delivery of care; and
7. Dealing with union issues de facto.

I just need your approval to get moving and to get Mac to help us start saving money.”

“Joe, I think you have done a wonderful job,” replied Jacobs. “Get to work and let’s get this hospital system in shape.”

Alexander quickly began to organize an implementation team. He brought in Second Chance Consulting Inc. and with the CFO selected 36 employees from each of the two hospitals to design changes. These employees were divided into three groups. One group was put in charge of access, one in charge of materials, and one in charge of delivery of care. The consultants set benchmarks of 20 percent reductions in costs in each area. Alexander was concerned that staff in the key areas might be resistant to changing their processes, and he wanted a fresh perspective. He therefore asked that all of the people invited to participate be assigned to areas outside their own. He also decided not

to include any of the hospital managers and department heads, believing they would not represent the best for the hospital as a whole.

The teams spent a total of six weeks intensively designing new standardized processes that could be implemented across the two hospitals. At hospital roadshows, corporate personnel talked about the great changes that were being designed. Staffs were told that the changes would save the hospitals from ruin and reverse their fortunes.

However, some expressed skepticism. As the date of implementation neared, the hospitals' administrators—perturbed by what they considered a show of disloyalty—told managers that those who did not support the effort should look for other work. Dissent immediately went underground, and the administrators believed they finally had all managers on board.

At the end of the six weeks, a detailed “battle plan” was crafted to reengineer the organization. Four from each team were retained to implement the designed solutions. The rest of the team members were disbanded. Each employee involved in designing the changes was given a laptop computer as thanks for his/her work.

The first action was to eliminate two-thirds of the nursing mid-managers. This change was projected to yield savings of \$2 million per year. It was instituted to promote team-based authority among the nursing units, although many nurses feared that quality and communication would suffer.

Other changes soon followed. The cafeteria was eliminated; patient food menus were minimized; a new position combining food service, housekeeping, and transportation was created; and the admissions staff was cut by half, among other major changes.

Hospital executives required that the changes be implemented, but managers and employees found that many were impractical. Some issues caused by the changes were not addressed, such as admitting Medicaid patients after half of the admissions staff had been eliminated. Access to the hospital slowed to a crawl because many Medicaid patients had to wait for verification of benefits. The elimination of the cafeteria forced employees to bring in food or leave for meals, reducing employees' work time. The minimization of patient food menus was a disaster. The three same menus were rotated over and over, and dinner on Wednesdays was always the same: corned beef and cabbage. Patient complaints about food skyrocketed.

The hospital unions also complained and refused to cooperate. The new position required a lot of cross-training, and the union demanded wage increases for each new skill employees had to acquire. Most new positions increased existing personnel's wages by about \$1.00/hour. Materials management was decentralized, and 18 new people had to be hired as a result; this change seemed to increase, not decrease, costs.

Although the changes clearly were not producing positive results, managers were reluctant to express their concerns to hospital administrators. The executives remained positive and were certain that the changes would save their hospitals. Alexander continued to be a big supporter of reengineering and cited sabotage and bad attitudes as

reasons for the lack of success. His focus was to stay the course and fully implement the plan. He reminded managers that loyalty and commitment were required to move forward.

After a tumultuous year of implementing the changes, the hospitals' financial losses accelerated. Costs did not decline significantly, but the number of patients declined. Employee and patient satisfaction were at an all-time low. St. John's board of trustees became concerned and began to question the organization's direction.

Questions

1. What problems arose during the reengineering at St. John's?
2. How could the executives have improved the process of change at St. John's?
3. What next steps would you have recommended to the corporation's board?