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From the Desk of R. Lewis Dark...

THE DARK REPORT

RELIABLE BUSINESS INTELLIGENCE, EXCLUSIVELY FOR MEDICAL LAB CEOs/COOs/CFOs/PATHOLOGISTs

Restricted information, see page 2

Commentary & Opinion by...

R. Lewis Dark

Founder & Publisher

Regionalization And Consolidation Continue

STORIES IN THIS ISSUE REVEAL HOW PERVASIVE THE TRENDS of regionalization and consolidation are. Whether one agrees or disagrees that managed care is the future of healthcare, it is obvious that regionalization and consolidation will continue to transform healthcare.

Consolidation transformed the commercial laboratory industry. Consolidation is now transforming hospitals, directly impacting hospital-based laboratories. But I find it fascinating that consolidation is also transforming the health insurance industry. The story on page 16 about **Aetna's** acquisition of **New York Life's** NYLCare HMO business will directly touch clinical laboratories. There will be changes in how laboratory services are contracted as a result of this acquisition.

It is important to recognize that changes in every segment of healthcare will directly alter how clinical laboratories deliver testing services and get paid for those services. That is why shrewd laboratory executives should watch the various mergers, acquisitions and earnings announcements of the major players in healthcare. Their successes and setbacks teach us which management strategies are worth emulating and which strategies to avoid.

Persistence also contributes to success in the healthcare revolution. **Middle Tennessee Healthcare Network** (MTHN) provides an interesting example of persistence. After three years of planning and effort, the regional laboratory network is about to commence formal operations. Executives at MTHN tell THE DARK REPORT that the economics continue to look favorable. If the network can implement its business plan, it projects a doubling of outreach testing volume for its participating hospital laboratories. That is a goal which merits the effort.

Having acknowledged these market trends, I continue to wonder about the pursuit of "bigness" at the expense of profitability. The three blood brothers demonstrate that huge size creates little value if the laboratory cannot earn a profit. It seems like the national HMOs are learning that same lesson, given the sizeable losses posted by companies like **Oxford**, **Pacificare**, and **Kaiser**.

With **MedPartners** posting an $840 million loss, I wonder if large size is about to curse the physician practice management (PPM) industry with financial losses. As clients and regular readers of THE DARK REPORT know, I believe strongly that value-added services, delivered locally, is the key to sustained profitability. That is certainly not the strength of healthcare's multi-billion dollar behemoths. TDR

Tennessee Lab Network In Start-Up Preparations

Three years of rigorous business planning encouraged 12 hospital labs to participate

CEO SUMMARY: Planning for the Middle Tennessee Healthcare Network's proposed regional laboratory network took longer than expected, but not without good cause. Organizers of this laboratory network did their homework and created a solid business plan. Approval by CEOs from the participating 12 hospitals to launch operations was unanimous.

FEBRUARY WAS A MILESTONE MONTH in the business development of the **Middle Tennessee Healthcare Network** (MTHN). Papers of incorporation were filed and the regional laboratory network was officially brought into existence.

Middle Tennessee Healthcare Network is comprised of 12 hospital laboratories, covering greater Nashville and central Tennessee. The business design of MTHN represents a new organizational model for regional laboratory networks. *(See TDR, August 25, 1997.)*

After observing the experience of other regional laboratory networks, MTHN expects to avoid their mistakes while emulating their successes. "It would be fair to say that we were careful about certain issues. These related to invested capital, governance, and ongoing funding for network operations," said JoAnne Schroeder, CEO and General Manager of the fledgling regional laboratory network. "We tried to anticipate problems and build solutions into our business structure.

"It took three years of sustained business planning to attain operational status," she commented. "Our hospital CEOs finally gave us the official go-ahead this January. We incorporated as a limited liability corporation (LLC) in February."

Armed with authorization to proceed, MTHN is now assembling the management resources necessary to launch operations. Recruiting is under way for several positions. Unlike most regional laboratory networks, MTHN's business plan recognizes the need for full-time, paid administrative staff if the laboratory network is to be competitive and economically self-sustaining.

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Since December 1995, MTHN's participating hospitals funded the full-time position of CEO and General Manager. JoAnne Schroeder assumed duties as General Manager of the MTHN Laboratory Services Organization (LSO) in February, 1998. Three other administrative jobs are budgeted.

"Our initial search for a full-time director of sales and marketing yielded three candidates," noted Schroeder. "The final round of interviews is about to commence. We expect to have that position filled shortly.

"During the planning process, we recognized the importance of laboratory information systems," she continued. "The more advanced our LIS capabilities, the more competitive we can be in generating new business from physicians. That is why we intend to hire a full time director of information systems.

"Economics of a properly-designed regional laboratory network are compelling. That is why laboratory testing survived the decision-making process. "

"Given the growth of managed healthcare in Tennessee, it became obvious to us that our network would require a managed care specialist. This individual will be responsible for gaining provider status with different managed care organizations (MCOs) and servicing the needs of those MCOs. We have yet to start the search for this position."

The fact that MTHN is willing to fund dedicated, full-time positions for administration, marketing and information systems sets it apart from most regional laboratory networks. It is more common for regional laboratory networks to rely on volunteer efforts by laboratory directors in the network.

"The pace of change in the Tennessee healthcare market is fast," observed Schroeder. "We were not naive about the number of hours it would take to administer this network and market our laboratory testing services to both physician offices and managed care plans. Part-time volunteer help from our laboratory directors would be insufficient to maintain our implementation timetable. That is why we created a business plan which funds dedicated, full-time administrative positions within the network."

Business Vehicle

The original founders intended MTHN to be the business vehicle for a variety of healthcare services. Yet after three years of meetings and study, only laboratory testing has moved toward operational status.

Schroeder offers thoughts on why this is true. "The original hospitals which founded MTHN wanted to provide a variety of clinical services to Nashville and central Tennessee. They could see the value of creating a shared service infrastructure for healthcare services in this region.

"Because managed care is a growing influence in our area, sharing clinical services was seen as a way for smaller integrated healthcare systems in our network to be part of a regional infrastructure," she continued. "MTHN would also permit the hospitals to eliminate duplicate resources, save money and improve clinical services in the areas served by MTHN.

Easiest To Organize

"As it turned out, everyone recognized that laboratory testing services would be the easiest to organize on a region-wide basis," said Schroeder. "Economics of a properly-designed regional laboratory network are compelling. That is why laboratory testing survived the decision-making process while regionalization of other clinical services has yet to occur

within the Middle Tennessee Healthcare Network organization."

Despite the fact that regional laboratory network services of MTHN have yet to be formally launched, participating hospital laboratories already enjoy the benefits of a new reference testing contract. The economics of this arrangement are worthwhile

"While developing our business plan, we identified a number of support services required by the network," observed Schroeder. "After an extensive RFP process, we picked **Specialty Laboratories** of Santa Monica to be our reference laboratory partner.

"Among other things, this contract permits our participating hospital laboratories to save money on their send-out testing," she continued. "Thus, the network is delivering benefits to its member laboratories even before implementation of outreach testing services."

Lab Industry Milestone

Once Middle Tennessee Healthcare Network's regional laboratory service organization becomes fully operational, it will represent an important milestone for the clinical laboratory industry. Other business models of regional lab networks have struggled to find success. But MTHN's business model is unlike that of any other lab network.

It seems that MTHN's organizers have carefully crafted a financially viable business plan *(see pages 5-8)*. Assuming that the management team can do a good job of implementing the business plan, it would appear that MTHN has the potential to develop into a strong laboratory competitor in Nashville and central Tennessee.

Should that occur, then Middle Tennessee Healthcare Network's success will further validate the concept of regional laboratory networks as a viable market response to managed healthcare. TDR

(For further information, contact JoAnne Schroeder at 615-386-2680.)

Market Fears Motivate MTHN Lab Network

It was fear of fast-growing **Columbia/HCA** which spurred competing hospitals in Nashville to create the Middle Tennessee Healthcare Network (MTHN).

"MTHN was founded in 1995," stated JoAnne Schroeder, CEO and General Manager of MTHN's Laboratory Services Group. "You could probably say that Columbia was the 800-pound gorilla which motivated ten competing hospital systems to unite and form MTHN. Their goal was to use MTHN as the business delivery vehicle for a variety of shared clinical services."

As MTHN organizers began to develop the business vehicle, they quickly recognized that laboratory services would be a viable clinical service for the network to offer. "Early in the planning phase we recognized a threat and an opportunity involving outreach laboratory services," said Schroeder.

"The threat involved potential loss of managed care contracts for laboratory testing," she explained. "Our hospital labs already owned a substantial share of physician office testing We wanted to protect that. Conversely, we also recognized that we had the opportunity to double our existing outreach business if we could network our laboratories in an efficient manner."

From 1995 forward, planners concentrated on developing laboratory testing services. It will be MTHN's first shared clinical service to become operational.

MTHN Provides Lessons In Creating Lab Networks

Consortium of 12 Tennessee hospitals faced a variety of issues requiring effective solutions

CEO SUMMARY: Every regional laboratory network in the United States is unique. Regional variations in healthcare and business objectives are different in every case. But the management problems of network structure, governance, marketing and finance are always the same. Here are some useful lessons learned by the Middle Tennessee Healthcare Network.

PROBABLY NO OTHER laboratory industry trend has disappointed as much as that of regional laboratory networks. When the concept exploded onto the scene in 1995, it was rapidly adopted by many hospital laboratory administrators throughout the United States.

Two pioneering networks were widely promoted in 1995. Both failed to live up to their potential. In San Francisco, **Bay Area Regional Laboratory Network** (BAHLN), continues to operate. At launch, it numbered 18 hospital laboratories. But the pioneering network has yet to make any significant impact with managed care companies in the region.

In Pittsburgh, 40 hospitals joined the **Reference Laboratory Alliance** (RLA). It had a well-designed operational plan and was successful in acquiring provider status with the region's largest managed care organization. But the rapid evolution of two competing hospital systems caused a reversal in RLA's finances. The regional laboratory network ceased operations in early 1997.

Despite these setbacks to the regional laboratory network movement, there is still widespread activity in all areas of the United States. Two primary goals fuel networking activity: achieving provider status with managed care plans and lowering laboratory costs through shared testing.

Potentially Powerful Model

Last week THE DARK REPORT was on site at the **Middle Tennesse Healthcare Network** (MTHN) in Nashville. MTHN represents a potentially powerful business model for regional laboratory networks. Since 1995, its organizers have been diligent and thorough at attacking the same problems which derail or defeat other regional laboratory networks.

During the site visit, MTHN CEO and General Manager JoAnne Schroeder discussed how MTHN developed its solutions to the challenges of creating a viable regional laboratory network.

Probably the most important issue is financing. Many regional laboratory networks are under-capitalized from the start. Their business plans also fail to provide a source of cash

flow to fund ongoing operations of the network.

"At MTHN we recognized the crucial role of money," said Schroeder. "Case studies presented by regional laboratory networks at the *Executive War College* in 1996 and 1997 made us appreciate, in advance, that sufficient capital and operating cash flow were critical success factors."

Solve This Problem

"It was our goal to solve this problem while giving our participating hospitals an incentive to invest the necessary funds," continued Schroeder. "Thus, we decided to fund the network in three ways.

"First, initial capital funding was obtained by having the equity participants purchase shares in the network," she explained. "Each share cost $50,000. Four hospitals purchased two shares each. The other hospitals purchased one share each. That provided us with start-up capital of $750,000."

Did hospital CEOs hesitate to make this kind of investment? "As you would expect, any level of investment asked of our participating CEOs was not automatically accepted," said Schroeder. "However, we made it easier for them. We had already negotiated lower reference testing fees through a centralized contract with one national reference laboratory. Service under that contract had commenced in May 1997."

Send-Out Savings

"Money saved from send-out work at their hospital laboratory offset this $50,000 investment. So, we were really asking them to shift funds already budgeted for the laboratory. This turned out to be a good selling point," she stated. "The CEOs were comfortable with this investment when they realized it was simply redirecting money from their existing laboratory budget."

The second source of capital is actually a clever aspect to MTHN's business plan. Schroeder explains, "We minimized our capital needs up front by getting agreement from the equity participants to make ongoing capital contributions from the collected revenues of the laboratory network.

"A percentage of MTHN's ongoing revenues are designated as a capital contribution by the equity participants. In year one, 45% of revenues are designated as a capital contribution and retained by the network. This percentage declines and zeroes out at year six," she noted. "Administrative fees are 30%. The network will pay 25% of revenues back to each participating hospital for their testing. This will increase to 62% by the start of year six."

"...we recognized the crucial role of money," said Schroeder. "Case studies... made us appreciate, in advance, that sufficient capital and operating cash flow were critical success factors."

This appears to be an elegant solution to the funding of the regional laboratory network. By negotiating lower reference testing fees for its 12 hospital laboratories, on the front end, MTHN's hospitals could designate the resulting savings to be the initial equity investment. Ongoing capital needs are then funded from the actual cash flow generated by the network's laboratory testing.

It is also important that the network is billing and collecting the money. Many regional laboratory networks are not organized this way. Revenue dollars flow first into MTHN. A fee is deducted for network administration. The remaining funds are then distributed to the participating hospitals.

Joint Venture Hospital Laboratory Network (JVHL) in Detroit is another regional laboratory network where revenues flow first to the network and

are subsequently distributed to the participating hospital laboratories. JVHL is one of the few lab networks which is flourishing. *(See TDR, January 16, 1998.)*

Another issue which MTHN thinks it has solved without a major investment of capital is laboratory information systems. "It goes without saying that every hospital laboratory in our network operates a laboratory information system (LIS) which cannot connect with the others," commented Schroeder. "Incurring the expense to convert each hospital laboratory to a common LIS was out of the question."

"Given the reality of reduced staffing in laboratories today, it is unreasonable to expect laboratory administrators will have enough free time to manage a regional laboratory network on the side."

"Our chosen reference laboratory partner provided the solution," she added. "We use microscript application modules run from PC workstations. Our reference laboratory partner maintains an Oracle database repository. We will have a single entry LIS arrangement which collects, formats, sends out, retrieves, and reports laboratory data."

Although MTHN is gaining a variety of service supports from its reference laboratory partner, Schroeder pointed out that another goal of the network was to internalize its existing send-out work. "Based on a centers of excellence model, three of the equity hospital laboratories in Nashville will do reference testing for other hospital laboratories in the network. This gives us four reference laboratories to support MTHN."

To accomplish this and comply with appropriate local, state and federal laws and regulations, MTHN is organized as a joint purchasing entity. "This means that we hold the contractual responsibility with **Speciality Laboratories,** other reference laboratories and any managed care companies where we are a provider," said Schroeder.

Outside Billing Service

"MTHN is also using an outside billing service," she added. "It was recognized that coding and billing for outreach laboratory services is detailed and specialized. It was determined that MTHN could do a better job of billing outreach laboratory services than the hospital billing departments. We can offer better service, do it at less cost, and improve our compliance. The more administrative services we control, the more responsive we can be to our physician clients. We need flexibility and freedom of action if we are to successfully compete against commercial laboratories in our market."

Another area where MTHN learned from the experience of other regional laboratory networks is staffing and manpower. MTHN wants to avoid the problems caused by relying on volunteer administration.

Reduced Staffing

"Given the reality of reduced staffing in hospital laboratories today, it is unreasonable to expect laboratory administrators will have enough free time to also create and manage a regional laboratory network on the side," said Schroeder. "Our start-up budget includes funding for three full-time positions: an administrator, a marketing director and an LIS director. We are also budgeted to hire service staff as the need arises."

Joint Venture Hospital Laboratories (JVHL) of Detroit also recognized this weakness of volunteerism. In order to maintain adequate services and expand market share, the network eventually replaced volunteers with paid adminis-

trators handling administration, marketing, and finance. Since the change-over to paid administration, JVHL has found it easier and faster to respond to market developments and implement management projects.

Organizing the network has not been without its pitfalls. Like most regional laboratory networks, it took several years to move from concept to operation. "It is inevitable that our 12 hospitals needed time to trust each other. Historical relationships, institutional politics and a changing marketplace all compound the decision-making process," said Schroeder.

Equity Ownership Structure

"One key issue carefully studied by our CEOs was how to structure the equity ownership of our regional laboratory network," she added. "What legal arrangements were needed to determine how new hospital participants can be admitted? How would an equity member withdraw from the LLC? These are important concerns, because MTHN was a competitive market response to **Columbia/HCA**. This is why determining how hospitals could get in and out of MTHN was a major issue.

"Another little surprise which delayed us by three or four months were the attorneys," commented Schroeder. "CEOs and administrators from the hospitals understood what we were doing. But once it was time to execute the legal documents, lawyers for each hospital now entered the picture. Since they hadn't participated in the development process, they didn't understand the laboratory business.

"It took us three months to educate them about the laboratory business and the marketplace. Once they understood it, they were very supportive of the network and their hospital's participation. In hindsight, it would have helped if the lawyers had accompanied their hospital CEOs to the planning meetings."

THE DARK REPORT came away from this site visit impressed by some of the sophisticated business thinking contained in the business plan for MTHN's regional laboratory network. It appears that MTHN has solutions to the most intractable of problems confronting organizers of such networks.

Important Development

If true, this is an important development. Regionalization of laboratory services must occur in response to the growth of managed care and integrated clinical services. Regional laboratory networks are an effective market strategy. Any business plan structure that proves successful will aid the national movement towards regional laboratory networks and systems.

But as proved by the disappointing failure of Pittsburgh's Reference Laboratory Alliance, even a sophisticated, well-designed business plan is no guarantee of success should management inadequately respond to marketplace changes.

That is why a successful regional laboratory network must accomplish two things. First, it needs to develop a viable business plan which provides appropriate working capital. Second, it must field a capable management team to implement the business plan.

Good Implementation

To avoid the disappointments of failed regional laboratory networks, management of the Middle Tennessee Healthcare Network will need to be good with their implementation of the business plan and timely with their response to changes in the marketplace. If they can accomplish both, they may well become a major laboratory competitor for physicians' office business in Central Tennessee. **TDR**

(For further information, contact JoAnne Schroeder at 615-386-2680.)

First In A Special Two-Part Series

Selling A Path Practice Requires Knowledge, Savvy & Good Timing

CEO SUMMARY: Historically, there was virtually no market for buying and selling pathology practices. That is rapidly changing as the first pathology practice management (PPM) companies enter the marketplace. Their business plan requires them to acquire pathology practices if they are to grow and prosper. In the first installment of this special two-part series, we take a detailed look at the methods used to determine the value of a pathology practice. The second installment will provide pathologists with a checklist of do's, don't's and pitfalls in negotiating a sale.

PROBABLY THE MOST VISIBLE CHANGE to occur within pathology in 1998 is the arrival of pathology-based physician practice management (PPM) companies. By year's end, as many as nine such companies might be in the marketplace competing for business.

This will present many pathologists with a new business dilemma: should they sell some or all of their pathology practice to a physician practice management company? Whether the answer is yes or no, it will be essential for the pathologist to know how much money his practice is worth.

"It is important to understand that selling to a PPM is different than selling to another pathologist," said Christopher Jahnle, Managing Director of **Haverford Healthcare Advisors**, "A PPM is interested in acquiring a pathology practice because of its existing cash flow and its potential for sustained future growth."

Two pathology-based PPMs have experience in the marketplace. **American Pathology Resources** of Nashville has been active during the last three years. **AmeriPath, Inc.** of Riviera Beach, Florida began serious acquisition activity in early 1996. It went public in October 1997 and continues to acquire pathology practices at a steady rate.

At least six other pathology-based PPMs are known to be at some stage of development. **Pathology Service Associates** of Florence, South Carolina is a network-based business model which does not meet the strict definition of a PPM and is not involved in buying pathology practices.

"It is my opinion that an active market for pathology practices will emerge during the next 24 months," stated Jahnle. "If AmeriPath is joined by even two or three well-financed pathology PPMs, then there will be spirited bidding for the choicest pathology practices. This has to occur, because none of these companies can survive without 'rolling up,' or acquiring pathology practices. It is the only way they can build the revenue base necessary to sustain their company."

Jahnle's assessment is correct. Competing pathology PPMs will want to acquire the most desirable pathology practices in the United States. The implication is that pathologists should understand how a pathology practice is valued.

Such knowledge creates two opportunities for the shrewd pathologist. First, an informed pathologist can more successfully negotiate the highest price. Second, by understanding the elements which add value, the pathologist can restructure existing business arrangements at the pathology practice to make it worth more money *before* starting any sale negotiations with a pathology-based PPM.

"Pathologists should expect to see two different business models from PPMs," said Jahnle. "One is the employment model. The other is the equity model. By far, the most common model is the equity model. Probably 90% of publicly traded PPMs utilize the equity model.

Valuation Techniques

"I would like to outline the differences between the valuation techniques used by both models," he continued, "since pathologists will mostly likely negotiate with PPMs based on either an equity or employment model. Both are similar in many ways. The primary difference is how each model defines the cash flow stream that the pathology practice is giving up to the PPM.

"In the employment model, the PPM wants to acquire the entire practice and all its assets. It will normally pay some multiple of 'normalized' *earnings before interest and taxes*," said Jahnle. "That is the source of the term EBIT.

"The process of 'normalizing' earnings simply means that the employment model calculates the practice value based on salaried pathologists," said Jahnle. "Assume that typical pathology salaries in a market

average $200,000 per year. Any earnings distributed to the pathologist partners above that number are defined as excess earnings. The PPM uses the excess earnings figure to calculate a purchase price. Typically an employment model PPM will pay a multiple of four to seven times normalized earnings to acquire a pathology practice.

"The equity model PPM calculates a purchase price using a different method," continued Jahnle. "It determines a baseline figure for the total compensation paid to the pathologists during the year. It will take a percentage of this baseline income, varying from 15% to 40%, for its management fee. It will pay a multiple of four to seven times that amount for the income stream it wants to buy from the pathology practice."

"I can identify seven factors which influence the multiple a PPM will pay," explained Jahnle. "It is important to understand how each individual factor makes a pathology practice worth more to prospective buyers."

In simple terms, Jahnle is describing a process whereby the PPM determines a cash flow stream that it considers as "profit." The PPM will pay the pathologist partners between four and seven times that number to acquire that proportion of the cash flow stream.

But what determines whether a pathology practice gets four times its EBIT or seven times its EBIT? The difference in sales price at each multiple is considerable.

"I can identify seven factors which influence the multiple a PPM will pay," explained Jahnle. "It is important to understand how each individual factor makes a pathology practice worth more to prospective buyers.

"The first factor is size. The size of the pathology practice directly impacts the magnitude of the multiple," he said. "The larger the pathology practice, the higher the multiple.

"Second is profitability," continued Jahnle. "The greater the excess profit over the normalized level of physician salaries, the higher its value will be. Furthermore, those factors that enable a practice to have higher profit generally result in higher multiple as well."

Subjective Factors

"Several of the other factors are subjective," commented Jahnle. "Number three is stability and reputation. Obviously a buyer will value a practice that has an established, loyal customer base over a practice which holds tenuous contracts.

"Number four is market opportunity for the buyer. If a pathology practice is located close to other pathology practices which the PPM could buy, then a higher multiple would be warranted. The possibility of gaining new pathology contracts that could increase the size of the business would be reason for the acquiring PPM to use a higher multiple.

"Number five is timing. This is always important," stressed Jahnle. "Pathology PPMs have not been around for very long. Most pathology PPMs have just been formed. At this point it is a seller's market. As these new PPMs compete for business, the multiples paid will probably be higher today than three years from now."

Business Form

"Number six relates to the business form of the pathology practice; whether it is a partnership, S or C corporation, or LLC. Each business form can impact the multiple for a simple reason," he said. "It affects the adverse tax consequences of purchasers if they must buy the stock of the practice as opposed to its assets.

PPMs: Equity Versus Employment

Equity Model

The practice sells to the PPM a partial equity interest in the business. In exchange for a long-term management agreement, the PPM receives a set percentage of the practice's revenue less non-physician operating expenses. Under the management agreement, the PPM will provide the practice a variety of services such as administration, marketing, billing, etc.

Employment Model

In this model, the physicians sell total ownership of their practice for a sum of money. They become employees of the PPM. The employment model is not as common as the equity model because many states have legal prohibitions against the employment of a physician by a corporation. Employment contracts may have a term of 3-5 years.

"Number seven relates to the composition of your practice's professional reimbursement. This also affects the valuation. To the extent that it is heavily weighted towards Part A fees, or, for example, in Texas where substantial portions of the professional component result from clinical laboratory testing in the hospital, those might be considered risky. In that event, downward adjustments would be made to the valuation multiple."

Pathology Practice Values

On pages 13 and 14, Jahnle outlines how a typical pathology practice would be valued using both the employment model approach and the equity model approach. "In comparing the pricing formulas, it is easy to see how the PPMs determine what type of revenue stream is going to pathologist compensation," noted Jahnle.

"Once this determination has been made, the PPM will follow a pretty simple formula to determine what the specific purchase price will be," he added. "The more difficult negotiations involve the nature of employment agreements, terms of the management agreement (in the equity model), and any issues unique to that particular pathology practice."

Although a calculation of "normalized" income and EBIT is fairly straightforward, Jahnle points out that the composition of the purchase price can vary. Terms of the purchase must be negotiated and those discussions can become fairly complicated.

"Typically there are three components to the purchase price paid the the sellers," noted Jahnle. "The ranges given are based upon representative sales. It is important to recognize that each purchase transaction will be unique. Although every sale contains these three basic elements, the actual percentages will vary.

"First, there will be cash paid up front to the sellers," said Jahnle. "Anywhere from 33% to 60% of the purchase price may be tendered as cash. This is negotiable and depends on the quality of the selling practice, desire of the buyer and competitive market conditions at the time of sale.

Stock Provides Incentive

"Second, stock in the PPM will be offered, ranging from 10% to 15% of the sales price. This is designed to give the selling physicians a financial incentive to support the business objectives of the PPM. If the PPM has

Status Quo: Pre-Acquisition

Net Revenue	$3,000,000
Physician's Compensation	2,300,000
Non-Physician Operating Costs*	700,000
Total Expenses	$3,000,000
EBIT	$0

Physicians' Compensation
$500,000 per partner (4)
$150,000 per associate (2)

* includes certain physician-related payroll taxes and benefits.

the potential to go public, such stock might appreciate substantially in value.

"Contingent notes are the third component," noted Jahnle. "These may or may not be guaranteed. They typically are subordinated to senior indebtedness of the PPM. Payout of the notes may be based on future cumulative EBIT levels earned by the practice.

"Between 25% to 40% of the sales price might be in the form of contingent notes," he added. "Typically the notes are for three to five year terms and do not bear interest. If an earn-out matrix is present, the selling practice may get zero dollars if they hit 80% of their target, and up to 1.5 times the value if they exceed 100% of their target."

Jahnle's outline of the valuation process shows the rather objective process used to measure EBIT (earnings before taxes and interest). The major portion of the purchase price is based on EBIT.

"This demonstrates the essence of the PPM transaction," noted Jahnle. "Basically, physicians are giving up a percentage or portion of their income. This is true of both the equity model and the employment model.

"When pathologists sell their income, they are accepting a reduced annual compensation in exchange for cash and assets up front. That is the basis of PPM valuation methodologies.

"In these transactions," he continued, "there are a number of ancillary agreements and other factors which dramatically impact taxation and the governance structure of the pathologist's relationship with the PPM after the transaction closes.

"Under the equity model, what links the pathology practice to the PPM is the management services agreement, said Jahnle. "It is common for this agreement to last 40 years. It is executed between the professional corporation and PPM. It specifies the type of management services which the PPM will provide the practice and how the PPM will be paid. There may be an equity sharing kicker for growth in the practices revenues and operating profits.

"It is difficult to unwind this agreement," cautioned Jahnle. "Because of the importance of this management agreement, it usually takes longer to negotiate provisions of this agreement than the actual purchase price.

"Another ancillary agreement which is part of the sales transaction is the employment agreement," he added. "Employment contracts are part of the equity model and the employment model. Simultaneous with the management agreement, the selling physicians will sign employment agreements with their professional corporation.

"This is because the equity model PPM wants to know that all physician partners are covered by employment and non-compete agreements," explained Jahnle. "Obviously, with employment model PPMs, the employment agreement is of prime importance. Typically these employment agree-

Employment Model: Valuation

Valuation Calculation	*Status Quo*	*Adjusted*
Net Revenue	$3,000,000	$3,000,000
Physician's Compensation	2,300,000	1,100,000
Non-Physician Operating Costs	700,000	700,000
Total Expenses	$3,000,000	1,800,000
EBIT	$0	1,200,000
Purchase Price:		
EBIT	1,200,000	
Purchase Multiple	X 6.0	
Total Purchase Price	$7,200,000	

Physicians' Compensation: $200,000 per partner (4); $150,000 per associate (2)

Equity Model: Valuation Calculation

	Valuation Calculation	*Adjusted*
Net Revenue	$3,000,000	$3,000,000
Non-Physician Operating Costs	445,000	700,000
Net Practice Distribution (NPD)	$2,555,000	1,800,000
Post-transaction:		
Physicians Share (65% of NPD)	$1,660,750	1,200,000
PPM's Share (35% of NPD)	894,250	
Purchase Price:		
PPM's Profit Share	$894,250	
Purchase Multiple	X 6.0	
Total Purchase Price	$5,365,000	

Physicians' Compensation: $276,438 per partner(4); $150,000 per associate (2)

Transaction based on PPM buying a 40-year cash flow stream of 35% of the practice's net practice distribution (NPD).

Equity Model: Showing Post - Acquisition Division To Partners

Physician's Share (65% of NPD)	$1,660,750
Gross Dollars Available for Partners	$1,660,750
Less:	
Associates Salary	$300,000
Education and Seminars	25,000
Insurance	80,000
Taxes	150,000
Net Dollars Available to Partners	$1,105,705
Physicians' Compensation:	**$276,438 per partner (4)**

ments run two to five years with non-compete clauses.

"Despite the fact that PPMs are offering a lot of money up-front to purchase the practice, pathologists should carefully consider their long-term business and career needs," advised Jahnle. "After all, the essential element in the PPM transaction is that the PPM is buying a portion of the pathologists' income. So the question is: do you want it now, or do you want it over time?" TDR

(For further information, contact Christopher Jahnle at 610-407-4024.)

Executive War College Update

Innovative Management Ideas Theme of Laboratory War College

ONCE AGAIN, THE *Executive War College on Laboratory Management* promises to be the management event of the year. Scheduled for May 12-13 at the New Orleans Sheraton, the program features 26 presentations covering the latest developments in laboratory management.

As in past years, there will be case studies presented by some of the most innovative laboratory organizations in the United States. These include **Intermountain Healthcare Laboratories** of Salt Lake City, **UMASS Health System Laboratory** of Worcester, **Pathology Medical Laboratories** of San Diego, and **PAC-Lab Regional Laboratory Network** of Seattle.

"Early registrations are running ahead of last year," said Robert Michel, Editor of THE DARK REPORT and producer of the *War College*. "That is probably in response to the expanded program offered this year, plus our special emphasis on contracting for managed care services."

Managed Care Strategies

"As managed care grows in significance, it is important for laboratories to become more effective with their managed care strategies," noted Michel. "A number of specialists from some of the nation's largest managed care companies (MCO) will share techniques and strategies for building a better relationship with MCOs."

Another *War College* exclusive is the appearance of William Hagstrom, President and CEO of **UroCor, Inc.**, based in Oklahoma City. Hagstrom will discuss the development of disease management products based upon diagnostic tests. UroCor is a fast-growing, profitable diagnostics company which serves urologists nationwide.

Similar Profit Margins

"Another feature of this year's *Executive War College* is our strategic retreat program," noted Michel. "Last year we had multiple attendees from more than 63 laboratories and integrated delivery systems. In response to this, we have arranged for an expert strategic facilitator to be present. Those management teams using the *Executive War College* as a strategic retreat can schedule time on-site with this consultant at no charge."

Pathologists will have the opportunity to explore the impact of pathology-based physician practice management companies (PPM) on the market for anatomic pathology services. There will be presentations on the different business models of the PPMs, as well as legal strategies for selling pathology practices.

Total laboratory automation (TLA) also gets analyzed. **South Bend Medical Foundation** and **Health Network Laboratories** will be sharing their experiences with TLA.

Already well respected for its no-holds-barred, tell-it-like-it-is candor, the 1998 edition of the *Executive War College* will once again bring the best in laboratory management to the podium. **TDR**

Big Loss At MedPartners, Aetna Buys NY Life Unit

Healthcare "consolidators" losing money even as they maintain acquisition strategy

CEO SUMMARY: Consolidation of the healthcare industry may be continuing, but the process is not profitable for some of the country's largest corporations. Clinical laboratories will continue to be impacted by the financial fortunes of these major players. Here's why the troubles at MedPartners and Aetna/U.S. Healthcare presage more financial pressure.

TWO MAJOR COMPANIES in the healthcare industry made major announcements last week. Their activities reflect the impact of ongoing consolidation to healthcare services.

The most unexpected news came from **MedPartners Inc.** of Birmingham, Alabama. The physician practice management (PPM) company reported a fourth quarter loss of $840.8 million.

For laboratory executives, the reasons given for the loss are most instructive. Write-down of goodwill related to acquisition of physician practices is a major portion of the loss. Goodwill is the difference between the asset value of the business and the actual price paid for the business.

Acquisition Problems

Because MedPartners is writing down such a large amount, this is evidence that it either overpaid for the doctor's business at the time of acquisition, or the subsequent financial performance of the practice was significantly less than expected.

This was exactly what commercial laboratories experienced during the acquisition binge of the 1988-1994 period. Goodwill was a substantial amount of each laboratory acquisition. When the acquiring laboratory failed to retain significant portions of the acquired business, they were eventually forced to write down huge amounts.

Similar Write Downs

Within 90 days of each other in early 1997, **Quest Diagnostics Incorporated** wrote down $445.0 million, **Unilab, Inc.** wrote down $70.2 million, and **Physician Clinical Laboratories** wrote down $36.3 million. This was 43.2%, 35.6% and 41.0% respectively, of the laboratories' balance sheet intangibles. **Laboratory Corporation of America** has more than $800 million of intangibles, but has yet to announce a similar write down. *(See TDR, April 21, 1997.)*

MedPartners' write-down of goodwill was accompanied by another revealing fact: clinic expenses soared 71% in 1997, from $706 million to $1.21 billion! Overutilization at its clinics in southern California was claimed to be a contributing factor.

Within days of MedPartners' disclosure, **Aetna, Inc.** announced that it would purchase the managed healthcare operations of **New York Life**

Insurance Co. for as much as $1.35 billion. New York Life Insurance is exiting healthcare to concentrate on its core businesses of life insurance, annuities, and asset management.

Aetna Becomes Bigger

Aetna will add 2.2 million customers to the 13.7 million it already serves. New York Life's healthcare business is known as NYLCare. Its biggest HMOs are in Washington, D.C., Houston, and Dallas. It also has HMOs in Illinois, Maine, New Jersey, New York, and Washington. Aetna intends to operate the larger HMOs within NYLCare on a freestanding basis during the near future.

The decision of Aetna to acquire more healthcare assets concerns many financial analysts. Aetna reported a significant loss for 1997. It has struggled to integrate its regional operations with those of U.S. Healthcare, which it purchased in 1996.

For clinical laboratories, Aetna's acquisition of NYLCare further concentrates the buying clout of Aetna. An RFP process for laboratory services has been under way at Aetna for some time. Announcement of the laboratory providers for Aetna/U.S. Healthcare is expected in the near future. A limited or exclusive provider panel will affect regional and hospital laboratories in many cities around the United States.

Continuing Consolidation

Taken together, the announcements by MedPartners and Aetna reveal that consolidation of healthcare is continuing. But the process of consolidation is creating financial challenges to which no effective solutions are known.

The clinical laboratory industry was the first in healthcare to undergo widespread consolidation. The abysmal financial performance of publicly traded laboratories during the years 1995-96-97 is well-known. Between posted losses and government fines paid in the "Lab Scam" investigation during those years, the clinical laboratory industry bled almost $2 billion of red ink.

Although the clinical laboratory industry was first to undergo widespread consolidation, the process continues within other healthcare segments. Activity seems to be concentrated primarily among hospitals, physicians and insurance plans. The diagnostics industry has yet to see extensive consolidation, but it will occur.

The key lessons to be learned from the experience of MedPartners and other PPMs is that large size does not automatically translate into success. Healthcare is still a local business. National solutions cooked up in a corporate headquarters thousands of miles away have yet to prove they can make money in local markets.

If size does not guarantee financial success, then Aetna's acquisition of NYLCare may prove to be unprofitable. That would be bad for clinical laboratories. If health insurance companies are unprofitable, then it is difficult, if not impossible, to raise reimbursement levels for clinical laboratory services.

It is important for laboratory executives to understand the dynamics of the healthcare marketplace. Even as the three national laboratories struggle to regain financial stability, there is a window of opportunity for nimble regional competitors to increase their market share in that community.

But such sales and marketing activity is going to have to take place with the knowledge that insurance plans are struggling to make money. They are going to want to reduce current levels of laboratory reimbursement. That is why it is critical to keep an eye on the national healthcare market while competing at the local level. **TDR**

(For further information, contact THE DARK REPORT at 800-560-6363.)

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

Independent physician association (IPA) executives gathered in Orlando two weeks ago for the annual meeting of TIPAAA, **The IPA Association of America**. Because IPAs play an increasing role in contracting for laboratory services, THE DARK REPORT was in attendance to learn more about this phenomenon. Over 1,000 people showed up for the meeting.

ADD TO:...TIPAAA

IPAs are undergoing the same economic stress as clinical laboratories. Reimbursement is declining, legal issues are increasing and prosperity is elusive. Regional differences cause IPAs to have more power in some cities, less power in other cities. Information, both clinical and financial, is recognized as a critical success factor. Given the consensus among attendees that these are common challenges for most IPAs, it was striking that few success stories were shared. IPAs, and the physicians they represent, are under siege. There were many interesting parallels between IPAs and clinical laboratories. We'll provide additional in-depth reporting on this in the future.

Impath Inc. of New York City announced that it would offer the public an additional 2 million shares of common stock at a price of $33.25 per share. If successful, the company will raise $66.5 million. Impath provides diagnostic and disease management services relating to cancer. It is fast-growing and represents a new type of laboratory business model. *(See TDR, March 2, 1998.)*

CHANGES AT CYTYC

Cytyc Corporation, manufacturers of ThinPrep™, reshuffled its Board of Directors. Monroe Trout, a director, was elected Chairman. Trout is Chairman Emeritus of **American Healthcare Systems** (AmHS), a hospital purchasing consortium. Patrick Kennedy remains as President. Three venture capitalists resigned from the board and were replaced by new directors. Cytyc's stock price has declined and is currently trading around $25 per share.

At least one financial analyst is disappointed that **SmithKline Beecham's** merger with **Glaxo Welcome** fell through. Analyst Neil Sweig at **Southeast Research Partners** lowered his rating on SB from hold to sell. Analysts are beginning to acknowledge that the SB-Glaxo deal is dead.

An interesting career move was announced last month. Jack Holthaus became President and CEO of **LAB-Interlink, Inc.** of Omaha, Nebraska. LAB-Interlink is one of the major players in total laboratory automation. What makes this interesting is that Holthaus was formerly President of **Advanced Laboratory Systems** (ALS), an LIS vendor purchased by **HBOC** in 1995. At ALS, Holthaus and his team were working to add process control capability to the next generation of ALG's LIS software.

MORE ON:...HOLTHAUS

It can be speculated that LAB-Interlink wants to leapfrog competitors at providing a total solution for both lab automation and LIS. Holthaus brings the expertise necessary to blend both technologies into a compatible package. THE DARK REPORT profiled ALG's future vision for LIS software in its March 31, 1997 issue.

That's all the insider intelligence for this report.
Look for the next briefing on Monday, April 13, 1998

THE DARK REPORT

UPCOMING...

- *Part Two Of Selling Your Pathology Practice: Do's, Don't's And Pitfalls To Avoid.*
- *Reimbursement For Automated Cytology Proves To Be A "Mixed Bag."*
- *Hospital Laboratory Outreach Programs Continue To Succeed In Many Cities.*
- *Hospital Buying Consortiums About To Run Into Congressional Buzz-Saw On Restraint Of Trade Issues.*