Private Equity: What's in it for the Doctors?

Two healthcare business experts from RSM discuss important disruption trends that will leave many legacy companies in the same position that Blockbuster's video-rental business found itself as Netflix grew in popularity. Patients increasingly expect the same types of experiences in healthcare that they receive in consumer businesses.

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Privcap: One of the strategies that we've seen among private equity firms is investments in physician groups, whether it's dermatology groups or other groups, the doctors are the central elements of these businesses and yet the businesses are being essentially rolled up into larger platforms. Before we talk about what the role is, both operationally and economically for these doctors, for these positions, what exactly is the play here? What are these private equity firms hoping to do, how are they hoping to make money in combining all of these different physician groups?

Matt Wolf, RSM: Generally, it's increasing scale at a very basic level. Let's say you have four different orthopedic practices and each one has six or seven surgeons and each one has a dedicated biller and a dedicated office manager, you could combine those four practices under the same managed service arrangement with a management company providing some of those backend services. Maybe you can do it with a smaller headcount. Once you're at that scale, you can leverage some technology to do it more efficiently, you can improve lab cycle and really just combine these small almost cottage industry types of practices into a larger, more scalable operation. That's the historical play that many private equity groups are looking to create.

Privcap: When a private equity firm knocks on the door of a physician group, what kinds of questions are they asking? What are they seeking to learn about the group to the extent that it makes them want to make an offer?

Wolf: The important understanding to figure out is – what is the physician pipeline? Is this the type of practice where you have a couple physician owners and the rest of the physicians, the majority of the physicians are employed by those physician owners? Then the physician owners are in this situation where none of the employed physicians want to buy in and continue operating the practice and the initial founder or physician owners, if you will, are looking for a retirement, they're looking for an exit. Or is it a more robust practice, they are bringing in new physician owners all the time and they're not necessarily looking for that same kind of exit, but maybe they're looking to be a platform themselves and they want to grow and expand, add service lines, add geographies? I think that is as important to understand.

Richard Kes, RSM: Maybe the physicians 30, 40 years ago were looking to own a practice, build a practice, be a business owner, be an entrepreneur who really had the opportunity and autonomy to do what they wanted to do from a practice perspective. The physicians graduating today maybe have a different model or a different mindset and maybe they are looking more towards that employment model, maybe they don't want the risk or the ownership responsibilities.

Wolf: The other thing that's I think important to understand for any sort of private equity investor is when you go and approach a physician group, odds are good to excellent that they've been approached by somebody in the last few months, certainly within the last year if it's a group that's larger than three or four physicians. They've almost certainly been approached, so being able to articulate what's different about your strategy or your group or what you can bring to the table

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Privcap: When thinking about the most credible private equity investors that are operating and building platforms in the healthcare industry and approaching physician groups, what is the pitch to these doctors? What is the pitch from an economic point of view and also from a quality of life point of view?

Kes: Let's just say it's a hypothetical orthopedic surgery group and there's 15 owner docs and there's 20 employed docs, and maybe the 15 owner docs are towards the end of their careers, looking for retirement and looking for exit. Twenty years ago they might've expected to sell their practice to those non-owner physicians in their practice, perpetuating that kind of ownership model. Well, today the non-owner physicians maybe are looking at it and saying, "I really don't want to buy your business. I just want to keep doing what I do. I want to see my patients, provide great medical care, but I don't want to be a business owner." You're seeing a lot of those types of physicians say, "Let's just sell our practice to a private equity group so I can continue to provide medical care to my patients and not take on the business and the business risks of owning this business." You're able to retire and get your pay out if, but it's now a strategic or a financial buyer.

Wolf: I think that's really well said, Rick. That value proposition I think is usually along the lines of that quality of life improvement, whether it will allow you to retire or will take over the burden of managing your practice so that you can focus on providing medical care, focus on your family, whatever's important to you. These owner physicians are really being paid twice. They're being paid once as the owners of a successful business and they're being paid again as competent and experienced physicians, but they don't think about it that way.

I'll just use round numbers. If you have a physician owner who's paying him or herself $800,000 a year. Let's say the fair market value compensation for a physician of that same specialty in the same region who has the same kinds of volumes and outputs and quality scores is $500,000. Well, what that physician will have a hard time understanding is, "Okay, you buy my practice from me, why am I only going to make $500,000 a year going forward?" There's an education element there, there's an alignment element there and they often can have a hard time understanding this lump sum exchange for that a future stream of income from being a successful business owner. That's really where quality of life part comes into play. You separate it out and say, "Well no, look, you were being paid as a business owner, now you're not going to be a business owner. You'll get the lump sum payment and you'll have more time to do other things that are important to you."

Privcap: The service of these businesses are the service of the physicians themselves, and for them not to be properly incentivized to remain and make the business healthy is a danger.

Kes: Absolutely. And we're still largely, especially in the specialist physician world, in a fee-for-service model, kind of an eat-what-you-kill model. Let's say you're doing due diligence on a physician group where all of the physicians were compensated based off of volumes they produced and the patients they saw or cases they worked on, panels, whatever volume metric you want. And that's the historical context that you're doing your due diligence on. But then going forward, the compensation arrangement is different – it's less variable because of how that agreement is being structured given that they're no longer owners. You could see some very significant decreases in those volumes. That's important to understand. What will be the alignment going forward, what will be those incentives going forward and how might that impact my deal model and investment thesis?

Privcap: Are there certain types of practices that are more popular with private equity investors than others? For example, can you talk about the reimbursement risk? For example, is it the case that dermatology practices are quite popular with private equity investors because so much of it is paid for in cash as opposed to via insurance?

Kes: Dental practices were probably one of the first real roll-ups strategies in healthcare, at least in this century. You look at that model and you say, "Why was that the first entrance?" I think you hit the head of the nail with reimbursement risk. Dental care and the way dental insurance and dental reimbursement works is somewhat more predictable. It is a little easier to get your arms around the revenue recognition model of a dental service organization versus maybe a more complex health care organization that delivers a wider variety of services and has a lot more payer contracts and a lot more oddities within their revenue recognition model.

Wolf: I would add that changes to reimbursement models are almost always promulgated by CMS. If you say, "Okay, what are the most stable reimbursement models?" well, the ones that have the specialties where there's a significant portion of cash pay, like we talked about, which would in addition to dermatology would also include, most cosmetic plastic surgery, not really doing, for example, medically mandated breast reconstructions, but just general plastic surgery. And then, fertility clinics, certainly. Then you look at other specialties, you try to evaluate it and realizing that CMS starts a lot of these changes to reimbursement models, things like orthopedic surgery. We're seeing a lot of change in how, for example in how joint replacements are paid for. Some of the first bundled payment initiatives were around those. As you're looking at these specialties, just try to understand how much they touch Medicare and how much might CMS be focused on changing that reimbursement in order to improve the economics and outcomes.

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Privcap: Put yourself in a physician's shoes, thinking about possibly doing a deal with a private equity firm. Under the best case scenario, what would life be like partnered with a private equity firm? Then hypothetically under the worst case scenario, talk about life partnered with a private equity firm where things are not going well.

Kes: I think in the best case scenario, if you are a physician and you sell to this hypothetical private equity group, you have a private equity group who really takes on the business of your practice and leaves the medical care to you. It's two things: One, being able to continue doing the things that you enjoy and doing the things that you went to medical school to do – providing great medical care. Two, really being able to leverage the resources and scale that the private equity group brings you to bring new things to your patients that you never would've been able to do without them.

Wolf: Yeah, well said. In the worst case, let's forego any discussion of violation of corporate practice of medicine laws. As Rick mentioned, the physicians still have to make the medical decisions, so let's assume that. The downside case is that there is a private equity group partner that's now saying, "We're going to get you a set of steak knives if you do x number of hip replacements this month." The worst case would be thinking you have a partner and do as a physician the things that Rick just mentioned. I can focus on medical care, I'm not going to have to deal with the billing and administrative part and this is going to be great, I can do exactly what Rick said. Then the reality is, "Well, I'm still too involved in running the practice. I can't see the patients I wanted to and oh, by the way, I'm not really getting compensated to run the practice anymore because I'm not an owner or at least not an owner to the same degree that I was before. Now instead of me simply answering to my other physician partners for the performance of the practice, I'm now also answering to this private equity firm that is based in another time zone that I never see in person, they just kind of call to yell at me because volumes were only up 2% last month." ■

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