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Industry Voices—Private Equity May Be Repeating Mistakes with Physician Practice Management Companies

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During the 1990s, Physician Practice Management Companies (PPMs) and Dental Practice Management Companies (DPMs) emerged as one of the 'hot' sectors to watch. At an accelerated pace, independent groups of practitioners became attractive targets in serial acquisition "roll ups" being aggregated to take public in an over-heated IPO marketplace. These companies offered providers an economically attractive alternative to the traditional individual practice and provided institutional investors a new opportunity to invest in an emerging healthcare sector. Billions of dollars in capital was allocated into the PPM and DPM sectors, typically with the practice management firms buying the physical assets of a practice, and entering into long-term management agreements with the healthcare providers.

The pseudo "joint-venture" model was theoretically designed to offer the best of both worlds: professional management with economies of scale to realize operating efficiencies, and the negotiating leverage to improve reimbursement while retaining provider autonomy at the patient care level. It provided monetization alternatives for traditionally illiquid ownership interests in private practices, and access to lower costs of capital to facilitate growth. It was viewed by investors as a regulatory compliant means to deploy capital in the physician services sector that most states prohibited from working for entities not owned by the providers themselves.

With its explosive rise in popularity, the PPM sector alone grew to over 30 publicly traded companies with an aggregate market capitalization in excess of $11 billion at its peak in January 1998. However, by 2002, eight of the 10 largest publicly traded PPMs had declared bankruptcy, and many more were ultimately dissolved.

So Why Did PPMs Fail?

In short, the PPMs of the 1990s failed to deliver on the major benefits they initially claimed. Rather than achieving the operating efficiencies through integration and automation, they added extra administrative costs and management fees, often making practices more bureaucratic and less profitable. While initial PPM transactions provided liquidity to senior physician partners, the added leverage and reduced profitability limited the ability to grow acquired practices. This created a misalignment of interests and decreased productivity with the younger providers, who did not participate in the initial proceeds from the sale, often compensated at stagnant and decreasing levels of compensation.

PPM growth was limited to aggregating more revenue through an accelerated pace of acquisitions with no intrinsic value creation. High leverage ratios were used to fuel these acquisitions and drive stock price, but liquidity necessary to properly focus on integration was limited. These liquidity constraints impaired available working capital, strained relationships with physicians, leading to dissent and defections, contraction of margins and rapid decline in stock promises when forecasted profitability from economies of scale never materialized. Physicians moved to terminate the management agreements, ceased paying management fees, and initiated a death spiral for many PPMs and DPMs.

Litigation ensued against these practices, the results of which demonstrated the fragility of the business model. Most PPMs and DPMs were forced to liquidate as the only means of recovery to lenders and investors. In the

same herd fashion that fueled the sector's rapid rise, the capital markets rapidly retracted from the fallen sector with continued access to capital severely limited. The few survivors morphed into business models more akin to outsourced professional staffing companies.

Recent Developments

Fast forward to 2019, with evidence of a "back to the future" return to PPM/DPM popularity and irrational investor exuberance reminiscent of the 1990s.

In this vintage of PPMs/DPMs, rather than the public equity markets capitalizing rapid growth through consolidation, there has been a frenzy of private equity firms acquiring practices through leveraged buyouts, driving record level sector valuations with very high leverage. Each private equity firm believes they are deploying value-added roll up strategies. Yet most are encountering significant challenges in the successful integration execution required to achieve the economies of scale and synergy expectations inherent to the investment underwriting thesis. The principal question is if, or indeed when, the dominos will fall.

Early signs of failure are emerging, attributable to many of the same mistakes in execution, as well as the inherent regulatory challenges of structuring true alignment of economic incentives with provider affiliates. Given the Private versus Public ownership status of the preponderance of these companies, broad market awareness of impending failures will be stymied, with revealing indicators being the rise in cost of debt and below par secondary market trades in the sector. Decreasing numbers of institutional participants as a result of increasing credit exposure to underperforming and failing companies will most likely result.

According to a recent study by Weill Cornell Medicine, during the past five years more than 100 PPMs and DPMs platforms backed by private equity have emerged, with over 100 independent physician practices acquired in 2017 alone. In this vintage, initially a majority of these platforms were in consumer-facing sectors such as wellness, cosmetics, dermatology, dentistry and ophthalmology (e.g., dermatology and dentistry each have over 25 private equity platforms), they now span virtually the entire range of physician specialties from primary care and OB-GYN to gastroenterology, urology, orthopedics and oncology. PPMs and DPMs are once again entering into joint-venture style management service arrangements with physicians and dentists, with rapid growth being achieved through "roll-up" acquisition strategies eerily similar to the 1990s. In this vintage of the sector, the acquisition multiples for the larger private equity backed "platforms" have exceeded 12.0x EBITDA, with leveraged debt multiples in excess of 6.0x EBITDA, and EBITDA being used to underwrite these debt issuances often including "pro forma add-backs" approaching 25%. With this type of leverage, one could reasonably expect limitations of working capital to fuel intrinsic growth as liquidity will be consumed servicing the massive amounts of debt burdening these practices.

However, this time private equity firms claim things will be different. Pointing to technology, firms say broader adoption of electronic health records and artificial intelligence allow experienced physician-managers to create efficiencies that result in cost savings and increased economic and lifestyle benefits for physicians and dentists. Similarly, the trend toward value-based reimbursement and shared savings creates the opportunity for larger provider organizations to take on additional risks related to patient outcomes. This form of reimbursement theoretically permits these providers to qualify for potentially higher reimbursement under PPM models than physicians would otherwise be able to realize in independent practice. Furthermore, it is argued that today's younger physicians are comfortable with an employment model that reduces impediments to, and culture clashes within, these large more scalable practices. For this generation, the notion of someone else managing the business while they focus on practicing their craft, is much more attractive. Graduating medical and dental students today assume they will be an employed provider—which is very different from the mindset of medical/dental students in the 1970s and 1980s, often thriving in the sense of autonomy historically enjoyed in independent practice.

Buyer Beware for Investors and Creditors

While private equity firms and some healthcare executives say things have changed, today's PPMs and DPMs are ultimately selling the same type of services they did in the 1990s. While some may indeed realize on the value proposition, time will tell. However, at their core, the current models often offer significant upfront consideration for intangible "Practice Value" beyond the hard assets of the practice, with valuations underwritten based on forecasted management fees and other factors. Unfortunately, many of the same misalignments of incentives exist in today's PPMs and DPMs that caused them to fail in the 1990s. Some of these factors include:

- Most PPMs and DPMs allow senior partners to receive a significant cash payment at the time their practices are acquired in exchange for an agreement by the practice to pay an ongoing percentage of profits, creating a future limitation on cash available for compensation to junior partners and, in many cases, reducing the motivation for senior partners to maintain their productivity.
- Physicians nearing retirement in selling groups still receive the lion's share of the consideration while younger physicians lose income growth. This can make it difficult to attract younger physicians to join a practice post-affiliation with a PPM/DPM if incentives are not properly aligned.
- Margins for many physician specialties remain razor-thin, creating a challenge for management companies to generate enough cost-saving or incremental revenues to meet investor requirements.
- While value-based reimbursement creates opportunities for revenue enhancement, this is offset in many areas by a trend of managed care payors moving toward Medicare rate levels after the higher margins are extracted and reimbursement levels diminished.
- Management companies are taking control of incremental revenues sources (surgery centers, rehab therapy, imaging) making it difficult for physicians to increase their earnings through their own ownership of ancillary services.
- Physicians and dentists are continuing to receive equity as consideration for their practices. If the value of that equity drops, the PPMs and DPMs will see strained relationships with such practitioners as they try to exit the relationship and cease paying management fees, or alternatively flee the organization with a corresponding reduction in patient volumes.

The Implications

Many market observers are concerned by the accelerated re-emergence of affiliation-style joint venture arrangements given the fragility of these business models. As witnessed in the 1990s, there are a number of issues with these arrangements and the new vintage of PPMs and DPMs are likely to encounter the same challenges investors faced 20 years ago. Declining reimbursement and escalating labor costs, will make it difficult to sustain earnings growth for physicians and investors alike. Leverage and structural limitations inherent to the model make it difficult to attract new providers after the senior professionals, that cashed out, retire. Crafting the PPM and DPM economic and contractual arrangements with practitioners should be guided by the experiences of the past to ensure that the future 2020 does not take us back to 2000. Most importantly, investor and creditor constituents should seek timely intervention at early signs of distress. A major lesson in the demise of the sector in 2000, was the slowest to act were inevitably the most impaired. If and when the music stops this time around, there will likely be very few chairs left!

By Neil F. Luria and Gregory F. Hagood, Senior Managing Directors at SOLIC Capital Advisors, a leading middle market financial advisory firm providing restructuring, investment banking and distressed asset support services

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