Private Equity-Backed Management Companies and Podiatry

There are many pros and cons to these arrangements.

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How do you feel that private equity firms are changing the face of podiatry? If you know the history, you know that the acquisition of private practices is nothing new. Those who were practicing from 1988 to 1999 likely remember the rise and fall of Physician Practice Management Companies (PPMCs). These entities were composed of large-scale acquisitions of private practices. They were known as "rollups" and were fueled by Wall Street capital when taken public. The hope was that these groups could consolidate the private practice industry, bringing the discipline of corporate management to physician practices while taking advantage of economies of scale. At first, their stock prices zoomed. This was interpreted by many as "success" and accelerated practice acquisitions. In 1998, there were 39 publicly traded PPMCs with many more waiting in the wings to go public. The 1998 failure of a proposed merger between PhyCor and Medpartners—which would have created the largest PPMC in the country—turned out to be the beginning of the end for publicly-traded PPMCs.

In order to evaluate whether it is a good trend that today's practices are being acquired by private equity, it is important to understand the environment that first initiated the push for consolidation of the private practice industry and what has been learned from PPMC failures that were formed beginning in 1988.

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Advent of Managed Care

The primary model which worked well for podiatry until the end of the 1970s was solo or small group practice. At the time, most insurance plans were indemnity-based. Third party billing requirements and rules were far less complex, and when a practice experienced a profitability problem, management skills were not as essential as today; doctors could simply raise fees—with little pushback from either third-party payers or patients.

In the 1980s, managed care entered the picture, bringing with it reduced-fee contracts, capitation, complex billing, and physician contracting networks such as Independent

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Physician Associations (IPAs), Preferred Provider Organizations (PPOs), Physician Hospital Organizations (PHOs), and Physician Practice Management Companies (PPMCs). Few of these group practice models succeeded over the long term because they were unable to add meaningful value in areas important to physicians, patients, and payers. Most failed. IPAs and PPOs survived because they at least offered effective vehicles for enabling independent doctors to participate in contracts and negotiate better rates than they had been able to do on their own. For payers, the large size of IPAs also made it more efficient and less costly to negotiate and manage contracts.

Although the IPA continues to be an effective vehicle for contracting, had this model also been able to control quality at the point-of-care and demonstrate increased value for patients and payers in the same way that a more tightly integrated efficient group is able to do, there would have been no need to create new models. The primary challenge inherent in IPA and PPO models is that, by definition, the doctors in them are independent. Doctors are less committed to their groups as a whole and participate in them primarily to use their size to leverage bargaining positions for higher payments. Another challenge is created by the fact that the participants all are typically utilizing different software programs. These features alone stymie doctors who desire to improve the efficiency of their groups or demonstrate greater value to payers (i.e., superior treatment quality or outcomes using evidence-based medicine).

Physician Practice Management Companies

Even though most practice purchase models failed for a variety of reasons, the PPMC industry taught us several things that can be helpful in developing more effective models going forward. it was relatively easy to show that the single-specialty PPMs were far more efficient and effective than the multi-specialty ones—many outperforming the more diverse groups by as much as 30%. Many of the efficiency advantages of these single-specialty PPMs resulted from the fact that governance and business operations for this model were less complex and more easily standardized than those for multi-specialty models.

A large part of PPMC's strategy was the rapid acquisition of physician practices primarily for the purpose of quickly gaining market share and thereby boosting their stock value. To accomplish this, they accepted low paying contracts in exchange for greater patient volume. One of the reasons cited for the failure of PPMCs was that they were focused on market share made possible by these low paying contracts rather than on profit share. To give you an idea of profit share, in 1998, MedPartners, a PPMC that was acquiring and managing medical practices, also acquired Caremark, a drug benefit company.

Following this acquisition, managers found that while almost two-thirds of MedPartners' revenue came from its PPMC, this segment of their business accounted for only one-third of the company's profit. Conversely, Caremark accounted for only one third of total company revenue; yet, it delivered two-thirds of the profit. As company-wide profit continued to drop, MedPartners divested its PPMC business in order to focus on the more profitable drug benefit portion of its business. While this decision seems to have been a "no brainer," not all such connections between volume and profit can be as easily identified.

Other issues cited as the reasons that the PPMC experiment failed were that economies of scale did not occur as predicted, many doctors were dissatisfied with the management they received, PPMs were not delivering the value doctors had expected based on the promise they had been given that the income they had sold to the companies would be restored, and PPMs had overpaid for physician practice assets. The PPM equity that physicians received as a large part of their sale price was also devalued, and there was a general reluctance from office-based physicians to truly be part of a large organization, as opposed to "ruling their own kingdoms." Another challenge was that PPMs were burning through cash to support their substantial corporate overhead. One comment made by Jack Lewin, MD, who at that time was the executive director of the California Medical Association, was the following: "Doctors fear that this trend of ever-larger corporate management companies will lose sight of the goals of medicine because they are accountable to investors."

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Advantages of Group Practices

Whether created over many years through organic growth, accelerated by a practice merger, or result from a combination of the two, group practices offer many advantages, including the following twelve: 1) maximized efficiencies, 2) expanded opportunity to collect and analyze "best practices" and "quality" data, 3) greater negotiating clout, 4) expanded patient access, 5) marketing leverage, 6) greater access to capital, 7) the ability to afford professional management, 8) the opportunity to develop ancillary services, 9) the ability to provide competitive corporate benefits, 10) access to volume discounts from vendors, 11) the ability to offer a broad array of services, and 12) the provision of an exit strategy upon retirement.

That being said, if a group is not consistently pursuing the first two of these advantages—namely, 1) aggressively employing appropriate

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workflows and efficiency principles to build a high performance, low cost infrastructure and 2) collaborating on an electronic medical record to develop treatment protocols which have been proven to deliver better outcomes and can, thus, be utilized for the purpose of reducing treatment variation—it is unlikely that the other advantages of group practice will matter because overhead will spiral out of control, the group will become ever more complex to manage, quality will be inconsistent and difficult to control at all points-of-care, and participation in future "pay for quality" contracts is less likely to be achieved. A single specialty group that is backed by private equity should be able to achieve all twelve of these advantages.

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Private Equity-Backed Management Companies

The podiatric market is attractive to private equity for the following reasons: 1) an estimated 75 percent of the American population experience foot or ankle problems, 2) there is a growing geriatric population, along with a rising prevalence of chronic diseases such as diabetes, arthritis, and obesity, and 3) there are approximately 4,500 podiatric practices facing diminishing margins with the majority of these comprised of five or fewer physicians. These demographics make podiatric practices targets for consolidation for the purpose of creating economies of scale. Another factor that makes podiatry attractive to private equity is the fact that it is a single specialty, making it less complex to manage a group of these practices and easier to control their overall costs. Podiatric practices also offer considerable potential for adding diverse revenue streams from ancillary services such as diagnostic vascular and nerve testing, ambulatory surgery centers, wound care centers, physical therapy, pathology labs, and in-office dispensing of foot care products—just to name a few.

If you are unfamiliar with private equity firms, you should know that they typically invest in private practices expecting annual return rates of 20% or greater. To achieve these returns, they initially focus on acquiring "high profile practices," those described as large, well-managed practices that are reputable in their specialty. This not only helps as infrastructure to manage practices is being built, but acquisition of this type of practice also makes it easier to attract other DPMs to the network. Expanding growth is what makes it possible to spread a greater volume of patients and services over fixed costs. Growth also enables firms to exploit synergies across their networks of merged practices, expand ancillary profitability in which the margins increase as patient volume increases, and increase negotiating leverage with health insurers—even with the potential of increasing reimbursement when they can demonstrate how they are controlling quality across their networks through the appropriate use of electronic medical records.

Private equity firms typically take anywhere from 60% to 80% ownership in a practice; although, they will sometimes accept minority ownership in a very large practice or buy 100% of a smaller one. There are some private equity groups that have added MSO models that manage practices without necessarily acquiring them. The amount paid to practice owners varies significantly, and most equity firms look to sell their networks within three to seven years. In addition to the initial payment that owners receive, they also hope to participate financially in the subsequent sale of the network. This is commonly referred to as getting "a second bite of the apple." Most private equity sales of physician practices are to other private equity firms; however, if the opportunity to sell at higher gains starts to decline, some predict that the ultimate buyers could be hospitals or health insurers.

As mentioned, the focus of private equity backed management companies has been on specialties that have the potential for bringing in additional income from elective procedures and ancillary services. A variety of specialties are also being acquired by private equity. Certainly, dermatology, cardiology, and orthopedics are all attractive practices for private equity, as are many others.

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Since there are a number of private equity firms active in the podiatric market—all employing different strategies and models,—it remains to be seen which models will be able to achieve economies of scale, successfully employ value-based care, and emerge as success stories. The difference in strategy from the PPMC era is not only the focus on specialty practices. The earlier models were "roll ups" that went public to raise capital, and the managers had to build management infrastructure while at the same time focusing on shareholders who wanted to see growth in quarterly profit.

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Arguably, practice management software packages with fully integrated electronic health records running on the cloud were not as sophisticated at that time. There is no question that trying to manage a multi-specialty group from "afar," using suboptimal software, while at the same time needing to rapidly build infrastructure and focus on making Wall Street numbers was not a strategy built for success. The final measure of today's new private equity firms will be whether they are able to create networks in which doctors, patients, and payers are all happy and are also receiving the appropriate return on their investments.

Interviews with DPMs Who Have Sold Their Practices to Podiatric Management Companies Backed by Private Equity

This last section is a compilation of information garnered through interviews with podiatric physicians who have sold their practices to various management companies backed by private equity. Hopefully, from the previous discussion as well as from the comments made by doctors who are involved with some of these groups, you are able to determine whether you feel this trend will be a good option for our specialty over the long-term and whether you might actually consider selling your practice to one of these groups.

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The greatest concern from private practice doctors before they finalize their "deals" with private equity firms is that they feel they may be "surrendering their destinies." There is no question that those who are entrepreneurial and accustomed to running their own private practices will lose. My response to them is that, *"You sometimes first need to give up control in order to regain control."* Doctors need to recognize that they have already lost control of healthcare but that giving up some control here opens an opportunity to regain greater control in the future when dealing with payers, hospitals, supply vendors, and ancillary services.

During the course of the interviews, it became quite clear that there exist significant differences among these companies. On the surface, they all appear similar—basically, entities buying practices, managing them, focusing on growth and profit, and eventually selling the group as a whole. While profit is the primary focus of all companies (without it they will go out of business), they will all have significantly different cultures, priorities, strategies, missions, business processes, and management policies. This is true even for the companies competing in the same market—in this case, podiatry. This is why it is

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important to perform due diligence if you are considering joining one of these groups. As mentioned previously, winning models will need to optimize the needs of doctors, patients, payers, employees, and investors alike.

There was a difference in the interviewed doctors' satisfaction with their groups. Some were far more enthusiastic about their decisions and their future than others. Some had far more "pros" than "cons," but a few had the reverse. Without identifying which companies or doctors were interviewed, the following are some comments from these interviews. The following are some of the pros and cons expressed regarding the sale of their practices to participate in one of these groups:

Using the combined knowledge of the group, we were able to create best practices.

Pros

- Getting rid of the administrative burden was my primary motivation. I'm done at 5:00 PM. I can decrease my time in the office, and I no longer need to do "management" on the weekends.
- Business functions are streamlined, and management is no longer on the shoulders of the doctors. Management is time-consuming, which reduces the time we doctors have to earn income.
- We have been able to utilize resources not previously available.
- I no longer worry about running out of money or making payroll.
- Our group has added a variety of ancillaries that I did not have before.
- I wanted to be part of a group that was focused on value-based care.
- Using the combined knowledge of the group, we were able to create best practices.
- The group is able to start new doctors at a higher rate than most private practices can afford.
- The group has sufficient capital to take on contracts that have greater risk than a typical practice is able to do.
- Part of the decision to sell has much to do with your age and where you are in your career. One older doctor would do it again, but not at age 40.
- Because the group has practices in many different states, I have the ability to move with the company. Employed doctors could also move.
- I appreciate that we have marketing efficiencies, IT support, streamlined payroll, better health insurance, and 401K matching.
- There is unlimited earnings potential for all doctors—not just the owners. Each doctor is treated the same.

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Cons

- I am no longer in charge.
- No investments have been made to improve the practices.
- I thought I was getting out of management, but that has yet to materialize.
- We need to have better connection between management and physicians.
- Things do not happen as quickly as you would like.
- It takes time to build infrastructure. The focus is on growth rather than on infrastructure.
- We have yet to receive ancillary income.
- Product usage has been too streamlined. For instance, if I don't like a specific cam walker, I might just hear, "Well too bad."
- There have been more compliance issues.
- Even though most of us have ownership in the new entity, we still feel a loss of ownership.
- Management cut back staffing quite a bit.
- Each market varies. What works in one area of the country may not work in another, but it is sometimes hard to convince management of that fact.
- Staff loyalty is diminished because they work for the entity, not the doctor.

As far as the future is concerned, the doctors who were most enthusiastic about their groups were, of course, far more positive about the future of this model. In fact, they felt that over the long term, this trend will be good for our specialty. We are a shrinking profession with only so many options for employment. Most new doctors prefer to be employed, and these groups are hiring a significant number of new doctors; plus, there will soon be a need to replace the former practice owners.

The doctors who were, so far, enthusiastic about the success of their groups pointed out that while some groups have made mistakes, they still feel that this new option for the private practice model is far superior to those of the past. They feel that because requirements such as MIPS, MACRA, and compliance have become more burdensome, billing is becoming more complex, and companies have more leverage than private practice doctors had in the past, management by these companies allows a doctor to focus on patient care while the entity focuses on increasing the bottom line. One last thing is that the former practice owners as well as the new partners in these groups all expect to get a "second bite of the apple." Some even expect to get a third or fourth. **PM**

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