Schier Capital Group's Perspective on Physician MSOs: Where Does Private Equity Take the Model Next?

Introduction

Historically physician practices had limited options to 'monetize' practice ownership, primarily due to the corporate practice of medicine laws that exist in many states. However, through two cycles of physician practice management (PPM) and hospital affiliations over three decades, we have now witnessed significant consolidation in the business. Hospitals have taken the lion's share of acquisitions, but in both cycles, private equity has made significant inroads in consolidating practices. However, since not all practices will be interested in consolidating, as the number of 'consolidatable' practices declines, what does the future hold for the PPM industry? The future may be in private equity-backed multiple-specialty PPMs.

Practice Management – Where It's Been…

The mid-1990s saw the first cracking of the physician ownership obstacle as the early PPM companies circumvented this limitation by splitting the practices into two entities: one that owned the assets of the practice and collected receivables (dubbed the management services organization or MSO), and one that employed physicians and distributed income (typically the existing professional corporation). The early multi-specialty PPMs such as PhyCor, MedPartners, CareMark, and many of the single-specialty roll-ups, purchased the assets of the practices and took fees essentially as a percentage of the distributable income before physician compensation. These companies did not employ physicians and rarely created new professional corporations to employ the affiliated physicians. The standard fee received by the MSO in return for buying the assets and providing services was 15% of distributable physician income.

Most PPMs in the first wave of consolidation met an untimely end around the time of the tech bubble's bursting in 2000. PhyCor, MedPartners, ProMedCo, and others either filed for bankruptcy protection or sold the assets back to the physician practices (or both). The growth model had been targeted at achieving greater size in a market, increasing the physician practice's leverage with payors, and eventually taking capitation or subcapitation payments, and then recycling capital to continue the growth. Two primary issues led to problems for the first wave of PPMs. The larger multi-specialty PPMs mentioned above were banking on the continued penetration of capitation from insurance companies to set up the future of the acquired multi-specialty practices, however, capitation did not take off to the extent expected, particularly in the central and southern U.S. markets where PPMs had become most prevalent. Consumer/patient preference for choice, and the selection of PPOs over HMOs, effectively blunted the growth of the capitation model. Additionally, as the model stagnated, physicians were unhappy with the 15% reduction in their take-home pay and adopted a "What have you done for me lately?" stance toward their management companies. The answer was "Not much," so, coupled with the tech bubble implosion, the first wave of PPM consolidation quickly unwound.

Model that Worked

Several PPMs survived, however, specifically those in hospital-based medical specialties, which is particularly instructive for the direction the current wave of consolidation is heading. The PPMs specializing in anesthesiology, neonatology, radiology, and emergency medicine generally survived the first crash. Sheridan Healthcare, EmCare, TeamHealth, and others continued to grow, add physicians, and add contracts to manage their respective physician arenas within the hospital setting. Economies of scale and standardization were of great benefit in consolidating these specialties, and the focus was generally not on taking risk within the healthcare premium dollar. Also instructive to today's market, the compensation model used by these companies was one more focused on employment than on partnership. Physicians were paid before the MSO entity made its profit, so the optics were much better with the physicians. Another key factor that led to longevity and success was consolidation across these hospital-based specialties. The surviving PPM companies now offer multiple physician service lines, all within the hospital setting. Examples include: Envision, TeamHealth, and MedNax.

Recent Focus

Fast forward 20 years from the first PPM implosion, and private equity is again heavily focused on physician services - - and the interest has been growing for the last 10 years. Recent specialties of interest are those that focus less on inpatient services and more on outpatient services, ancillary services, and private-pay opportunities. Ophthalmology, dermatology, and dentistry were the initial darlings of private equity dating back 10 years when private equity dipped its toe back into the physician (and dental) services pool. Success was not predicated on taking risk from insurance companies, but rather focusing on ancillary service lines that could promote profit within the four walls of the clinic. As growth occurred in the number of physicians affiliated with the platform practice, efficiencies were achieved, reimbursement contracts were optimized, and the model yielded more profit within the practice. The compensation model has tended toward productivity-based employment, a lesson learned from the hospital-based MSOs, and the "What have you done for me lately?" refrain has therefore been infrequently heard.

Recent years have seen an expansion of interest across even more physician specialties, including specialties that are relatively small in terms of the number of physicians and practices available to consolidate. So, while ophthalmologists and dentists were all the rage for the last 10 years (and they continue to be), new efforts are being made in urology, gastroenterology, ENT, orthopedics, asthma/allergy, and other specialties. Though these are generally smaller fields of specialization, they are similar in their heavy emphasis on ancillary and outpatient services. As with ophthalmology and the like, growth within a geographic market is desirable and may eventually lead to more leverage with payors, but the focus is on ancillary and outpatient service development. Using the now-preferred employment contract based on productivity to drive the compensation model, value is created in the MSO, not the practice itself.

Where Do the PPMs Go from Here?

Looking at the playing field now, we have mature specialties that have been consolidating for 10 years or so, and we have newer ones. The commonalities are the outpatient and ancillary focus. So, what

happens as there are fewer and fewer 'consolidatable' practices? What is the exit for the private equity investor? Will we have multiple publicly traded urology and orthopedic PPMs? Likely not, and the successful hospital-based multiple-specialty roll-ups are the examples that guide this thinking.

Though urology, ENT, orthopedics, and allergy do not share too many patient referrals, there is a strong argument that these types of specialty PPM platforms and others can join together as the PPM market becomes saturated and private equity runs low on practices to acquire. These single-specialty roll-ups share key business principles that should allow them to consolidate into multi-specialty management companies. The key commonalities are: 1) employment model with base and bonus compensation centered around productivity; 2) multiple ancillary revenue sources including surgical procedures, injections/immunology, aesthetics, and other private pay services/procedures; 3) similar clinical set-ups and provider recruiting needs; and 4) common back office and administrative functions such as billing/collection, payor contracting, and non-clinical employee recruiting and retention. With so many commonalities, further support for consolidation includes: 1) the ability to remove duplication out of a combined entity (e.g., business development, revenue cycle, contracting, IT costs, C-suite, HR, accounting); 2) sharing value-based care strategies and costs; 3) capitalizing on the shift to outpatient care; 4) reduced capital costs for larger entities; and 5) reimbursement leverage with payors. With all these commonalities and other consolidation benefits, over time, a consolidating multi-specialty PPM, particularly one with strength in specific geographies, can be highly successful, similar to the consolidators in the multi-line hospital physician services business.