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Physician Practice Management and Private Equity: Market Forces Drive Change

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Historically, market forces have driven measurable change across all industries, and independent gastroenterology practices are no exception.

Gastroenterology in the United States remains highly fragmented with approximately 13,000 physicians, 2500 independent groups, and 40% of physicians in groups of 4 or fewer. Practices have faced challenges including declining reimbursement, payor consolidation, retiring leadership, implementation of information technology, competition from hospitals, restrictions to referral sources, recruitment challenges, staff management, new service lines, and increasing compliance and administrative burden.

The business components of medicine can be difficult for independent medical practices to manage efficiently. Maturing practices may consider selling their practices to regional health systems.[1] In recent years, hospitals aggressively have acquired physician groups, with the number of practices owned by hospitals and health systems increasing 63% from July 2012 to July 2016. By 2016, 29% of medical practices were owned by a hospital or health system, and hospitals employed 42% of all US physicians, with these numbers continuing to increase.[2] It is estimated that 70% of physicians in training today will be employed by a hospital or health system throughout their career.[3] Employment of gastroenterologists provides the hospital with clinical integration opportunities, improves their competitive positioning with payors, secures their referral base, and captures ancillary volume and outpatient facility fees. Employed physicians work more hours yet see fewer patients than independent practice owners.[4]

Hospital employment of gastroenterologists has its own challenges. Governance of the practice is ceded to the hospital. Purchasers and payers increasingly are requiring that procedures such as infusion and endoscopy are performed in outpatient settings when safe.[5] The transition to outpatient procedures results in lower gastroenterology-generated downstream revenue for the health care facility and subsequent alteration/renegotiation of financial arrangements with the employed physicians. The risk for physicians is that higher hospital salaries for less work can be transitory.

Even if not employed by a hospital, gastroenterologists may have a contractual relationship with a hospital. They can serve as the Medical Director of a hospital's service line, receive co-management incentives, or contract to provide hospital emergency room, indigent, and inpatient coverage. Physicians may represent referrals for hospital infusion centers, endoscopy and outpatient surgery suites, and anatomic and clinical pathology and imaging facilities. However, according to The Physicians Foundation in their 2018 survey, 46% of physicians indicated relationships between physicians and hospitals are somewhat or mostly negative. Furthermore, the 2018 survey highlighted that employed physicians work more hours, yet see fewer patients than practice owners.

The Need for Scale and Sophistication in Practice Management

In many industries, increases in competitive threats and management complexity leads to consolidation. However, consolidation is more than a search for size. To remain independent, physician practices will be required to dramatically improve their managerial talent, systems, and processes. It is a common refrain that most businesses fail because of a lack of capital. Gastroenterology practices are starving for capital to grow amidst the mounting pressures. Dealing with these challenges requires significant capital to hire, build, and advance. With so many threats to an independent practice, it is not a surprise that physician leaders have looked to new business models to sustain growth and thrive during challenging times.

Abbreviations used in this paper: EBITDA, earnings before interest, taxes, depreciation, and amortization; GI, gastrointestinal; LP, limited partner; MSO, management service organization; PE, private equity.

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Several themes consistently appear when discussing the greatest challenges faced by independent physician practices across the United States:

- Lack of managerial metrics and dashboards (ie, is clinical quality increasing or decreasing?);
- Tremendous administrative burden, carried largely by the physicians;
- Underpaid management teams, creating challenges to recruit experienced talent;
- Lack of understanding and management related to revenue cycle management;
- Reimbursement challenges and payor relations;
- Referral concerns: hospital acquisitions of primary care and specialist physicians;
- Lack of scale to effectively optimize ancillary services;
- Struggle to create win–win relationships with local hospital systems;
- Challenge for rural and smaller groups to recruit new physicians;
- Need for capital to invest in new Ambulatory Surgery Centers, information technology systems, and recruit new associates.

Private Equity

Private equity is composed of investors that directly invest in private companies that are not listed on a public stock exchange. Private equity (PE) firms raise funds from limited partners (LPs). LPs often are large pension funds, university endowments, corporations, and wealthy individuals that desire to invest a portion of their holdings in investments that have the potential to produce a higher return than more conservative investments. LPs entrust their funds to the PE fund manager to invest within the life of the fund, which most commonly is 10 years. During the life of the fund, the PE firm invests in a number of companies, and then helps guide those companies to greater strength and success before selling the company to a future investor, which may be another PE firm or a strategic investor in a similar or adjacent market.

Markets that attract private equity investment include those that are highly fragmented, in which the competitive landscape is shifting, leadership is under-resourced, companies lack scale, and capital is scarce. Experienced investors and managers proactively seek these opportunities because they have the required understanding and capital to intervene and make a positive impact on the organization to increase value, particularly in growth markets.

Table 1. Private Equity Investment in Medical and Dental Specialties Over the Past 20 Years

Specialty	Initial private equity investment	Private equity portfolio companies
Dental	1996	35
Pain management	2008	6
Dermatology	2011	21
Ophthalmology	2014	11
Gastroenterology	2016	3
Urology	2016	3
Orthopedics	2017	7
Obstetrics/gynecology	2017	1

Although investment by private equity in medical practices began more than 30 years ago, there has been increasing interest in partnering with independent specialty practices during this decade (Table 1).

Private equity presents an alternative to acquisition by a health system and may help physicians feel more in control of their practices, while meeting their needs for investment capital to continue their growth. The capital provided by private equity can be used to leverage expertise in financial discipline and business operations to improve care delivery, fund new technology, hire employees, build infrastructure, make acquisitions, expand working capital, and to bolster and solidify a balance sheet, while retaining medical practice leaders as their clinical decision makers.[6] PE can bring proven expertise and economies of scale to resource-intensive aspects of a medical practice including information technology, regulatory compliance, human resources, revenue cycle management, payroll, benefits, and facilities management.[7] Health care executives gave PE high marks on improving regulatory compliance, tracking clinical outcomes and patient experience, and the ability to support acquisitions and grow the top line.[8]

Physician Motives

When examining why physicians would enter into an arrangement with private equity, one cannot view all physicians as a monolithic group. Gastroenterologists may have different motivations based on the stage of

their career. Older physicians in a practice that has built ambulatory surgical centers or added a pathology laboratory have no exit strategy for the fruits of their labor except selling to the remaining partners. This may be prenegotiated, but often is done at the time of retirement, and usually for a very moderate amount. Decades of hard work, vision, and risk taking may receive a very small reward, unlike other business owners who have built profitable, ongoing, and often growing enterprises.

Younger physicians buying into a profitable practice often see the dangers lurking in health care: disruptive technology, single-payer systems, declining reimbursement, and competition for patients with tax-exempt health care systems. Physicians who may be facing high tax rates for regular income may be willing to exchange some current income for equity that can grow in time and be taxed more favorably upon selling. Physicians in the middle of the age spectrum see the same risk and may view the option to take some chips off the table, exchanging equity and capital gains now for a portion of the proceeds as an intelligent hedge for the future.

Similar to other companies, physician practices face new risks as they attempt to scale. Because the majority of gastroenterology (GI) groups are still fewer than 10 physicians, the challenges of growth are very real. True scale in GI, including a management team and mature infrastructure, typically is experienced as groups get closer to 75 to 100 physicians. The larger groups are able to spread the fixed costs of the organization across more providers, thereby allowing the group to have more capital to invest in people, processes, and systems toward delivering a higher level of care, with a reduced administrative burden.

The Nuts and Bolts of Private Equity and Physician Practice Management

Most private equity investors seek to invest in companies with an annual regular cash flow stream. The cash flow typically is referred to as earnings before interest, taxes, depreciation, and amortization (EBITDA). EBITDA is an indicator of the company's profits and ability to generate cash. When valuing companies, including health care companies, private equity investors frequently base their valuations on a multiple of the company's EBITDA. As an example, if a company reports an EBITDA of $1 million and it is valued by investors at a multiple of 5×, then the company can be sold for $5 million.

Valuation multiples vary depending on factors including historical growth rate, profitability, established infrastructure, market dynamics, competition, market size, management talent, and potential for future growth. This valuation method is not unique to health care and holds true for companies across multiple industries. However, although it is common for companies to retain profits and reinvest in future growth, a medical practice typically distributes all remaining profits to its partners, so the practice does not pay taxes on the remaining profits held in the company. Therefore, it is uncommon for a medical practice to report a positive EBITDA.

When a physician practice determines that they can benefit from an experienced health care PE investment partner, the entities can form a management services organization (MSO). The MSO provides comprehensive management services to the practice in exchange for a fee. This fee creates an income stream upon which private equity investors can derive a valuation for a medical practice (Figure 1).

In a typical transaction structure, upon creation of the MSO, the physician partners receive: (1) proceeds from the initial investment, (2) shares of ownership in the MSO, and (3) compensation going forward.

To ensure future alignment, approximately 30% of partner proceeds typically are invested into the MSO, often referred to as equity rollover—rolling forward to an anticipated gain in a future transaction. MSOs work to optimize the back-office and information technology capabilities, recruit talented managers, and improve the clinical quality and strength of the practices to which they provide services, so they increase in value. Thus, the owners of the MSO are aligned to growing and building a high-quality practice. When the MSO is sold to a future investor, or a second bite at the apple, the initial founding group partners and other partners that invested in the MSO during the holding period likely would receive proceeds based on the added value of the MSO equity.

Although the process of forming an MSO and PE partnership may be highly complex, several key issues receive most of the attention during a transaction.

Ownership

PE firms typically require a majority ownership in the MSO, which controls the business decisions related to the nonclinical staff and operations. The physician partners typically own a large minority position in the MSO and both parties have a vested interest in future success. Associate physicians typically do not receive proceeds

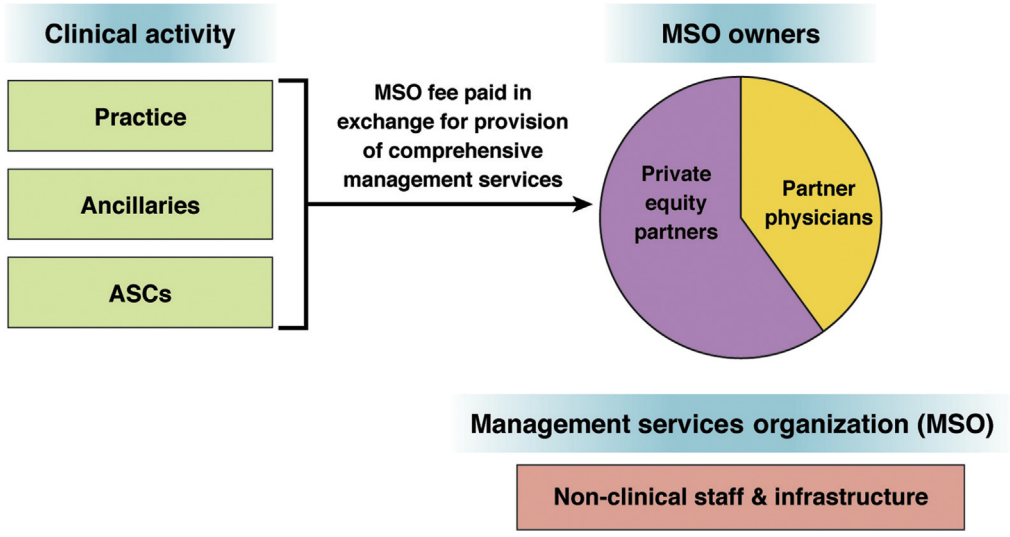

Figure 1. Management service organization (MSO) structure, an illustrative example.

from a transaction and do not have ownership in the MSO. However, associates may have an opportunity to buy shares in the MSO as they become partners in the future. In some cases, the partners may use their discretion to accelerate associates who are nearing partnership status.

Autonomy

Physicians are concerned about autonomy in 3 areas: clinical decisions, compensation, and vacation. PE firms typically agree that physicians must maintain clinical autonomy. Existing clinical leadership structures often are maintained to govern clinical practice. Vacation and compensation details are clarified through formal agreements, in advance, so that all parties have a clear understanding before any partnership is finalized. In a PE partnership, the MSO management team assumes responsibility of the day-to-day nonclinical decisions related to practice management, including: compliance, accounting, revenue cycle management, information technology, business analytics, human resources, payer negotiations, marketing, procurement, acquisitions, and related business decisions.

Future Investment

In most physician groups, the partners must assume personal liability and bear the burden of contributing to future investments for new ASCs, establishing ancillary opportunities, hiring new associates, and so forth. With a PE partner, the MSO bears the burden of financial responsibility.

Key Considerations When Partnering With a Private Equity Firm

Key considerations are as follows:

- PE experience: just as experience is important to distinguish leading physicians, experience is equally important to distinguish leading PE firms. Physician practices benefit by partnering with PE firms that specialize in health care and have decades of relevant physician practice management experience.
- Pathway to partnership: partnership requirements vary widely among medical specialties, and also among GI groups across the United States. For example, a pathway to partnership in dermatology groups is less common than in GI groups. PE firms typically strive to respect the existing culture and expectations for partnership within individual groups, but the expectations must be clarified on a go-forward basis.
- Growth strategy: organic growth must be a key component of the future growth strategy for any medical practice. Overutilization of debt can become a burden if the economy slows and interest rates increase. Furthermore, acquiring additional practices at lower values may be helpful, but depending on these financial levers alone will not be sufficient to achieve acceptable returns on investment.

Consolidation among hospitals, payers, and physician practices is expected to continue for decades to come.[9] This process represents the nature of a free

market system as market forces increase complexity and demands on the independent physician practice. In a competitive environment, history points to winners working from a position of strength, with scale and sophistication.

Supplementary Material

Note: To access the supplementary material accompanying this article, visit the online version of *Clinical Gastroenterology and Hepatology* at www.cghjournal.org, and at https://doi.org/10.1016/j.cgh.2019.05.001.

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Conflicts of interest
This author discloses the following: Joel Brill has served on the advisory boards/consulted for Aimmune Therapeutics, Aries Pharma, Astellas Pharma US, Augmenix, Avella Specialty Pharmacy, Baxter, Biogen, Braeburn Pharmaceuticals, Bristol Myers Squibb, Cardinal Health, Diopsys, Diversatek, Dune Medical, Echosens, EMD Serono, Endogastric Solutions, EO2 Concepts, Exalenz, GeneNews, GI Therapies, Gilead Sciences, Glaukos, Halt Medical, HepQuant, ImpediMed, Indivior Pharmaceuticals, Insightec, Lumendi, Mallinckrodt Pharmaceuticals, Medtronic, Natera, Pacira Pharmaceuticals, Proteus Digital Health, Rebiotix, Seno Medical, Senseonics, SonarMD, Sunovion, Tusker Medical, UCB Pharma, and Vertos Medical, and has options/warrants with GeneNews and SonarMD. The remaining authors disclose no conflicts.

Supplementary Methods

Looking Back and Looking Forward

A skeptic might ask how physician practice management in 2019 is different from the physician practice management companies of the 1990s. A few of the key differences are highlighted in Supplementary Table 1.

In the 1990s, PE firms were more focused on cost cutting and physicians have been characterized as more fiercely independent. In 2019, PE firms are investing with a growth thesis, whereas physicians appear to be more team-oriented and open to alternative business models.

Five years ago, Becker's Hospital Review stated, "Physician practice management (PPMs) failed in the 1990s because it was premature and poorly executed—not unsound. Twenty years later, PPMs have a clear strategic rationale and value proposition. Indeed, the need is stronger than ever."[1] The growth of private equity investments in both specialty and primary care may represent validation of this evolution.

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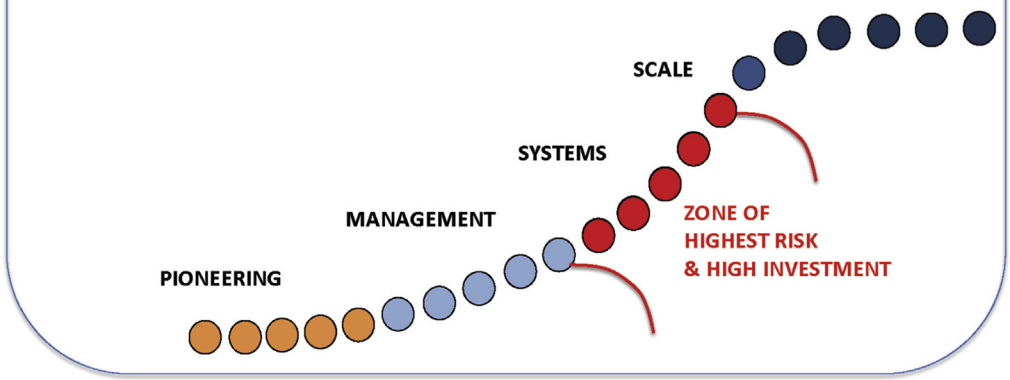
Company Evolution & The Challenges of Growth

	Startup	Growth	Take Off	Maturity
Cash Need	Low	High	Very High	Medium
Complexity	Low	Medium	High	High
Systems	None	Limited	Robust	Robust
Recruiting C Level Talent	Extremely Difficult	Difficult (equity required)	Easier (equity required)	Easy (equity required)



Supplementary Figure 1. Stages of corporate evolution and the challenges of growth. Excellence in provider services will require a deep understanding of operational excellence from organizations with true scale and sophistication. Gastroenterology practices may need to look for such excellence outside of the specialty, toward groups that have scaled to thousands of physicians leveraging advanced systems and processes. To date, although few management teams have built organizations of such scale in Gastroenterology, we expect to see those emerge in the coming years. With capital investment and improved business operations, we expect to see more Gastroenterology practices with advanced systems and fully integrated services, allowing practices to deliver high-quality, efficient, and effective care across the Gastroenterology service line.

Supplementary Table 1. Physician Practice Management Characteristics Evolving Over the Past 20 Years

1990s		2019
More likely to join a small group Captain of their own ship	Physicians	More likely to be employed More team-oriented
Focused on cost cutting Aggressive HMO/PPOs	Payers	Controlling referral patterns Acquiring primary care providers and specialists
Focused on building inpatient-centered service lines	Hospitals	Acquiring practices, hiring physicians (PCP, GI, oncology, cardiology, and so forth)
Basic operations	Administrative burden	Exponentially more complex: EHR, MACRA, MIPS, compliance
IT systems very expensive and ineffective Focused on hardware	Technology	IT systems more cost effective Focused on software and analytics
Focused on cost cutting Not aligned with physicians	Private equity	Focused on growth Completely aligned with physicians.

EHR, electronic health record; GI, gastrointestinal; HMO, health maintenance organization; IT, information technology; MACRA, Medicare Access and CHIP Reauthorization Act; MIPS, Merit-Based Incentive Payment System; PCP, primary care physician; PPO, preferred provider organization.