Pursuing the Private Equity Model for Hospital-Physician Transactions—A Viable Option

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Hospital and physician alignment transactions typically fall under a few common structures, the two most common models being practice acquisitions with physician employment, and professional services agreements (PSAs). Another option is available, however. The market for the purchase of medical practices by private equity (PE) firms has shown significant growth in recent years, with expectations the trend will continue. This article will discuss hospital and physician alignment transactions that occur under the PE structure and how they differ from traditional transaction models; address private equity buyers and the advantages and disadvantages of PE acquisitions; and conclude by taking a closer look at private equity-like transaction models between hospitals and physicians.

What Are the Options?
Physician groups looking to sell now have more options as they look for buyers other than hospitals. Some practices are exploring the possibility of selling, usually in part, to private equity (PE) firms or private equity-backed platform companies. These transactions differ from typical hospital-physician deals in structure and terms. Following are some common characteristics that describe these PE-based models and the qualities that make them unique:

Hospital Acquisition of the Practice with a Physician Employment Agreement
1. The acquisition usually includes only tangible assets; thus, minimal upfront money is necessary.
2. The practice usually sells ancillaries separately at fair market value (FMV).
3. The compensation plan is typically based on individual physician production, along with some quality incentives.
4. Acquisition normally makes sense for primary care or practices where the priority is to reduce risk and attain more income stability over upfront dollars. Some specialty practices are also of interest, depending on the field.

Professional Services Agreement
1. The practice maintains its independence but receives no upfront money due to no sale of the practice. The tangible assets may be sold or more likely leased through the PSA.
2. The practice can sell its ancillaries separately at FMV; however, these may be included in the overall transaction and, therefore, considered only within the tangible asset valuation and sale.
3. The PSA rate is based on a group rate per Work Relative Value Unit (wRVU); payments are usually distributed by the practice, subject to their income distribution plan (IDP).
4. The PSA typically applies to specialties, such as surgeons or proceduralists, where reimbursement has declined significantly (and employment often more difficult), as well as in areas where ancillary reimbursement has decreased, such as cardiology.
5. Surgical practices are more likely to have ancillaries with a higher value (e.g., ambulatory surgical centers (ASCs)), which would garner upfront dollars if the hospital acquires those ancillaries.
6. The PSA arrangement essentially is the same as going to a single-payer contract where the PSA rate with the hospital ultimately becomes the sole payer and sole source of revenue.
7. The practice maintains the flexibility to determine how it will distribute compensation dollars to the group; however, the practice retains some risk and overhead obligations through their independence, though the hospital often reimburses for overhead as a pass-through cost based on an agreed-upon budgeted total. Other typical employment requirements, such as restrictive covenants, etc., are in force.

Private Equity Acquisition of The Practice
1. Generally, upfront value, i.e., intangible value or enterprise value in the practice, comes from the application of a physician compensation reduction.
2. The compensation reduction, known as “the haircut,” is treated as newly created EBITDA, which can then be applied in a discounted cash flow (DCF) model that determines enterprise value. Also, a market multiple approach can be considered wherein the value is determined based on a varied rate akin to current comparable transactions.
3. The haircut is permanent, so physicians may make less income.
going forward; however, they would receive the value of that reduced income in upfront dollars.

4. Some prospective offset to the haircut may come through improved access to services and organic growth.

5. The new owner may decide to sell or consolidate the practice quickly.

6. Typically, the PE firm attains a majority interest, and the seller retains a significant minority interest. This joint ownership allows for a second bite in that the minority interest, along with the PE majority, may sell for an even higher multiple some three-to-five years later.

7. Also, the transaction may afford some favorable tax opportunities. Depending on the structure, the proceeds (or a portion) may be taxed at lower capital gains rates.

Private Equity Purchasers

Private equity deals involve a purchase by privately funded groups that come in all shapes and sizes. The acquisitions have primarily centered on specialty areas, such as dermatology, pain management, anesthesia, and dental practice arenas that offer the potential for additional income. The forecasted shortage of primary care physicians could make these medical practices attractive, as well. Standard surgical/proceduralist specialties are also realizing interest in—and completing—many transactions. These include ophthalmology, orthopedics, gastroenterology, urology, and others.

To achieve their desired returns, private equity firms focus on acquiring platform practices that are large, well-managed, and reputable in their community. These practices serve as flag-planting opportunities within a new area, too. The firms sell these practices after augmenting their value by recruiting additional physicians, acquiring smaller practices to merge with larger practices, increasing revenue (e.g., bringing pathology services into a dermatology practice), and by decreasing costs by substituting physician assistants for physicians. Growth makes it possible to spread fixed costs, exploit synergies across merged practices, expand ancillary revenues, and increase negotiating leverage with health insurers.

Physicians are understandably concerned about the impact that private capital and possible conflicts regarding the quality and affordability of care to patients and payers—might have on patient care. Thus, it is in the best interest of PE firms to leave all decisions about patient care in the hands of the physicians. Every state has its own set of corporate practice of medicine laws and exceptions, and many prohibit the corporate practice of medicine. Essentially, a corporate entity is prohibited from having control over the independent clinical judgment of a physician.

Many PE firms use a physician practice management model to acquire the non-clinical assets of a physician practice and enter into a management agreement with the practice. The physician entity holds the payer contracts; provides patient care; and employs the physicians, nurses, and clinical personnel. The legal distinctions are important because they reinforce a critical boundary in the practice of health care. In the end, the relationship between a physician practice and a PE investor/partner must be one of trust, including each party’s ability to excel at their respective roles, both of which should be centered on patient care.

A Private Equity–Like Alternative

Hospitals have been reluctant to pay significant upfront dollars to practices in the past, and for good cause. Medical practices fundamentally have no intangible value as they, in effect, distribute all of their profits as excess compensation to their physicians/partners. The FMV of a medical practice is therefore typically limited to tangible assets. While all entities are under compliance limitations, hospitals undergo the most scrutiny. PE firms or private, for-profit corporate entities are not under as much regulatory constraint, but they are concerned for return-on-investment (ROI) purposes. The PE model facilitates succession planning and may appeal more to the older physician, who is five or fewer years away from retirement. Conversely, younger physicians are often less interested in a PE transaction, given that they are usually in the earlier stages of their medical careers.

The perspective on affiliation is shifting slightly, although not on the value of medical practices. Some hospitals are exploring whether they could use the same structure as PE firms in acquiring medical practice entities. Hospitals maintain their position against paying significant upfront dollars tied to intangible value alone; however, they may explore more significant upfront money if those dollars link to something more tangible, such as the compensation haircut. This concept makes sense because, until now, hospitals have watched PE firms enter their local markets and write large checks for practices, followed by the implementation of significant changes that have had broader implications, as well as some adverse effects on the local health care market. In addition, this model has a unique component for how a valuation can be derived, which can increase the appeal for physicians and increase their likelihood of partnering with a hospital (rather than a PE firm) under this type of structure, which is addressed in greater detail below.

What is the Seller’s Priority?

Before discussing the valuation in these transaction structures, it is essential to understand the key deal drivers from the practice’s perspective. In evaluating options from the practice’s standpoint, the initial question the seller must answer is, “Why are we doing this?” Specifically, “What is our highest priority to achieve in doing a deal?” On the flip side, the buyer must ask if one of the following considerations is a priority for doing the deal:

1. Maximize the upfront value.
2. Accept lower upfront value in exchange for a more stable income. Maintain income but reduce the risk of reductions from the Centers for Medicare and Medicaid Services (CMS) and commercial payers.
3. Remove the risks and difficulties of running an independent practice.
4. Maintain independence while attaining income stability.
5. Partner with another organization to increase opportunities for income diversity.
Figure 1: Acquisition by PE Firm

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Revenue</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>Total Physician Compensation (Pre-Haircut)</td>
<td>$25,000,000</td>
</tr>
<tr>
<td>Total Number of Physicians</td>
<td>10</td>
</tr>
<tr>
<td>Haircut (10%)</td>
<td>$2,500,000</td>
</tr>
<tr>
<td>Reduced Compensation per Physician</td>
<td>$250,000</td>
</tr>
<tr>
<td>Multiple on Haircut</td>
<td>9</td>
</tr>
<tr>
<td>Transaction Value</td>
<td>$22,500,000</td>
</tr>
<tr>
<td>Proceeds of Transaction per Physician</td>
<td>$2,250,000</td>
</tr>
</tbody>
</table>

6. Address the needs of succession with the practice.
7. Maximize value via the initial and second transaction (sale).
8. Address succession planning and access to capital for this matter.

If the selling physicians’ primary objective is to maximize the valuation paid at the time of the transaction and forego their independence to a hospital or PE firm, then the PE model may be their best option, especially for primary care or a group with few ancillaries. The PE model is probably the only real option for maximizing upfront value for that type of entity. However, even with ancillaries involved, that will only increase the upfront value if the hospital will purchase them, which makes this structure even more appealing to surgical specialties.

How does the valuation work in the PE model? The approach is relatively simple, though significant technical analysis, modeling, and assumptions must occur to derive an accurate dollar amount. Generally, the following factors are the critical components of calculating enterprise value in the PE model:

1. Determine the haircut (i.e., compensation reduction) to be applied across all physicians.
2. Develop a pro forma financial model in which the haircut is ultimately turned into EBITDA, with growth over a five-year projection period. (Note: Although there are critical and detailed steps that must go into developing these models, for this discussion, the assumption is the model follows all relevant and appropriate standards.).
3. Calculate a DCF valuation model using the financial tenets from the pro forma. This calculation will obtain an enterprise value for the entity following appropriate guidelines and standards. Again, a caveat also may be to apply a market approach using an EBITDA multiple.

The following table (Figure 1) illustrates a high-level, generic description for how the process works, showing how the numbers might calculate (Note: This example is hypothetical and uses round numbers that are simple to follow):

In Figure 1, each physician in the group receives $2.25 million in upfront value for his or her practice (assuming the even distribution of the proceeds), compared to the $250,000 in compensation relinquished each year. This model also assumes the PE firm applied a multiple of 9x to the haircut amount to derive their transaction value. However, few true market multiples can apply for such deal models. As such, applying a multiple against the haircut to derive the value entails a varied multiple in each transaction, based on the financial resources, risk, and flexibility of the parties involved. (Note: This valuation calculation relates solely to the sale of the practice. If the transaction includes the sale of ancillaries or other related entities, these assets would be valued separately and ultimately bring additional value to the sellers in those deals. Typically, the ancillary services are a separate legal entity, such as an ASC, or for purposes of the transaction, is treated separately.).

To validate the upfront dollars, the standard approach for applying this model with PE firms is for the haircut to be a permanent reduction applied throughout the life of the post-transaction relationship. The PE investor requires this to allow an adequate ROI over a relatively short timeframe. Then, there likely could be another transaction or liquidity event soon after. Another point worth mentioning is that after all analyses are completed, a discussion regarding salary reduction would be appropriate. Depending on the length of the relationship, the reduction is really a swap of up-front funds versus compensation over several years, with the latter being lowered but offset for the funds received at closing. While the factors of present value and capitalization rates are in play, the funds received at closing from either a hospital or a PE firm are, in essence, compensation received early. Further, some of those monies may qualify for more favorable capital gains income tax rates.

The potential differences for a hospital pursuing a transaction with a practice under a PE-like model compared to a PE firm transaction are the following:

1. A hospital can factor in its ROI in a variety of ways;
2. In most cases, it would not consider flipping the practice in five or fewer years as a PE firm often does, which makes a longer-term affiliation more likely; and
3. A hospital’s outlook is different, which creates room for flexibility in the structure and economics of a potential transaction. While the regulatory constraints are considerable, opportunities still abound for a mutually beneficial affiliation.
How Can Hospitals Compete?

Hospitals that are competing with PE firms must be willing to provide more upfront value than what is offered under other models. A hospital, generally, would not seek to purchase a medical practice by writing a check for as high an upfront value as a PE firm. But, the hospital-driven PE model has the potential to present a more appealing offer wherein it implements the haircut for a defined, limited period, such as in three years. Instead of the sellers receiving all their intangible value upfront in exchange for a permanent compensation reduction, they could pursue the same structure where the upfront value is less than a PE offer (though significant), with compensation restoration after a relatively short period (generally three years).

The hospital-driven PE model could potentially look like the numbers provided in Figure 2, using the same generic figures from our previous chart in Figure 1:

In Figure 2, the value of the practice was derived not by using a multiple applied to the haircut, but by applying a DCF model. This process is separate and requires a discussion that explains the mechanics and how a valuation is derived. However, it is a valuation methodology widely used and accepted if implemented under the proper guidelines and standards. Nonetheless, the monetary value of the practice paid through the upfront proceeds of the transaction is less than the value paid in the PE acquisition. The more important distinction is that while the physicians received $1.913 million in upfront dollars, this amount was in exchange for giving up $750,000 of compensation over three years. After Year Three, though, the compensation is restored with appropriate increases, meaning the physicians would continue to receive value from the transaction going forward, more, in fact, than if they did the same deal with a PE buyer.

Both scenarios have merit. Both are worthy of consideration, but aligning with PE firms generally stems from very different perspectives than aligning with health systems. Aligning with a PE firm offers a corporate mentality that is profit motivated. Health system affiliation provides economic opportunities, as well, but typically include a longer-term strategic, community, patient care-driven, and even mission-supported objectives. Although both are worthy of consideration, the practice should first evaluate and determine the reasons it wants to pursue alignment and then, attempt to connect with the appropriate partner.

Conclusion

In evaluating a PE-like structure, the primary question is what the physician-sellers hope to obtain from a transaction. If they want as much money upfront without concern about the impact on future compensation, then a hospital may not be the best option. However, if they seek a significant portion of the practice’s value off the table through the upfront distribution of funds while maintaining the ability for the restoration of this compensation after a time, the PE-like model can be attractive for both a hospital and the physician group.

Endnotes

1. Earnings before interest, tax, depreciation, and amortization (EBITDA) is a measure of a company’s operating performance. Essentially, it is a way to evaluate a company’s performance without having to factor in financing decisions, accounting decisions, or tax environments.
2. Lawrence P. Casalino, MD et al., Private Equity Acquisition of Physician Practices, 170 ANNAIS OF INTERNAL MED. 114 (2019).
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