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THE CORNER SERIES

Episode 93: The Compensation Mistake PPM Investors Regret, With John Tiedmann

Episode Summary

"The key to successful physician practice management is self-control on the sell-side and being reasonable about compensation," observes John Tiedmann, a managing director at Physician Growth Partners, in this conversation with host Geoff Cockrell. With over 70 deals across various medical specialties, John describes how PPM investments have evolved from pure growth to facing challenges in physician alignment and compensation structures.
The discussion highlights emerging pharmaceutical distributors as strategic buyers for large platforms and explores how compensation models are adapting to ensure sustainable practices. Despite recent headwinds, he remains bullish on the sector's future as platforms correct alignment issues and valuation expectations normalize.

Transcript

Voice over (00:00):

This is The Corner Series, a McGuireWoods series, exploring business and legal issues prevalent in today's private equity industry. Tune in with McGuireWoods partner Geoff Cockrell as he and specialists share real-world insight to help enhance your knowledge.

Geoff Cockrell (00:18):

Thank you for joining another episode of The Corner Series. I'm your host, Geoff Cockrell, a partner at McGuireWoods. Here at The Corner Series, we try to bring together dealmakers and thought leaders at the intersection of healthcare and private equity. Today I'm joined by John Tiedmann, managing director at Physician Growth Partners, which is one of the leading investment banks that focuses quite a bit on provider services in particular, so PPM model type deals. John and his team have done numerous, numerous PPM related deals. That sector has been all tailwinds for a long time, and now it's a mixture of tailwinds and headwinds. And we're going to talk a little bit about those and some emerging trends in that space. But John, if you could give an introduction of yourself and Physician Growth Partners, and then after that we'll jump into some questions.

John Tiedmann (01:05):

Yeah, Geoff, thank you so much for having me. Excited to be here. Again, my name is John Tiedmann, I'm a managing director at PGP. I've spent my entire career in investment banking in M&A advisory in healthcare. The preponderance of that for a decade now has been advising, and as you mentioned, the PPM space, physician groups related ancillaries, and the facilities in which they operate really is kind of the scope of our work. PGP was founded in 2018 to cater specifically to that subset of clients. All of our clients are sellers. All of our clients are sort of first institutional capital exploring partnerships with private equity or the strategic platforms that exist in the physician practice space. And we've worked, at this point, I think since 2018 when the firm was founded, we've done over 70 deals. We have spanned almost every specialty at this point, if not every specialty, from dermatology and ophthalmology to orthopedics and cardiology and sort of everywhere in between. So excited to be here and chat with you today.

Geoff Cockrell (02:12):

So John, as I mentioned for a while, there was all tailwinds in the PPM arena. Consolidation was fairly easy. There's a number of levers you could pull and have a successful growing consolidation business. Those tailwinds have turned some into headwinds. What have been some of the headwinds that people have been encountering in the PPM space?

John Tiedmann (02:32):

As you can imagine, as private equity sponsored community has spent time in this space, there have been a significant number of learnings when it comes to investing in physician practices. I think the biggest one, and where you've seen hesitancy from a new platform standpoint or caution on behalf of the private equity firms is really alignment with physicians and making sure that you're setting up a model that continues to allow these doctors to be excited to come to work every day, right? They eventually forget about that upfront check. How are they being compensated? Is the platform growing? Are they seeing their equity value on their rollover increase quarter over quarter, year over year, such that they have a strong belief and conviction that that second bite is going to be something meaningful and even a third or a fourth bite down the road.

(03:25):

And so really an intentional reshifting of focus into how that alignment is created and how to keep those physicians excited to come to work every day has been maybe not a headwind as much as a reorientation to make sure that you're setting these things up right from the outset. And maybe resetting some things internally for some of the platforms that realize that perhaps they didn't have something quite right. I think on top of that, interest rates and overall economic speculation has been a headwind that seems to be subsiding now, or at least we have clarity, right? Or stability is probably a better word, with respect to the interest rate environment and making it hopefully a little bit easier for the sponsor community to model out what their capital structure might look like. And/or how they're going to finance that next acquisition and what they're able to pay for that. The other, what was maybe a tailwind and then a headwind, and now is starting to normalize, I think is just overall valuation expectations on behalf of the sellers and the buyers, right?

(04:28):

With some of those fluctuations in the overall market. I mean, there was a heyday in, call it 2021, where valuations were pretty sky-high and the physicians who didn't sell remember that still. And for a while, there was a disconnect in the market between sellers and buyers and where valuations should sit in a given specialty. And I think as time has gone on, the running of the business of a medical practice has not gotten any less complicated. Perhaps there's some stability on staffing cost, but it's still a lot more expensive than it was even a few years ago given everything that happened through COVID. And so there's still a motivation for these physicians to find those partners. And I think that as time has gone on, expectations of value on the side of the buyer as well as the side of the seller have come back into, or at least closer to parity, which is allowing the market, I think, to open up a little bit.

Geoff Cockrell (05:26):

Yeah. So you mentioned balance sheet problems with the cost of capital. I think that's absolutely correct. Valuation distortions, that's correct. The one I'd probably add to that is we went through a few cycles where labor markets were their own pressure, just the leverage that labor had in general and in providers in particular, especially coming out of COVID, that was just another further distortion that put pressure on these relationships of providers to these practices. Maybe focusing on the alignment that you mentioned, so you've got alignment through a couple different dynamics. One is the second, third or so bite at the apple, so the value of rollover equity or equity that they're holding through other mechanisms, but also current compensation.

(06:14):

And the whole model, especially on the sell side, you're scraping a certain amount of current dollars that they were getting to create EBITDA that they're selling. And obviously maximizing that in the sale is a good thing because you're going to be paid a multiple on whatever was scraped. To my mind, that has put a lot of pressure on current compensation. So when you're looking in the sale context, how do you think about balancing the alignment in the form of go-forward equity versus go-forward current compensation? And I'll telegraph my bias, and that is that the spectrum got too heavy onto valuing the rollover and not enough focus on aligning current compensation on a year-by-year basis. But how do you balance those?

John Tiedmann (06:55):

Yeah, look, I am obviously a sell-side banker, and so the allure of creating as much EBITDA as possible by scraping as much future income as possible is obviously there. And it's certainly there even within a group that might have younger 30 something, 40 something physicians starting or maybe in the heyday of their career versus older physicians who don't have as much time left and therefore say, "Well, I can give up more." Right? And the key to all these things is first and foremost, expectation management between the sell-side advisor and their client. And secondly, I think self-control on behalf of everybody on the sell side and being reasonable with respect to how much you're scraping, what is your go-forward comp going to be relative to what it was prior to the transaction.

(07:43):

And what are the opportunities for this colloquial term income repair, right? The idea that as time goes on, different things might happen within that practice that drive growth. Hopefully, if you've set it up correctly, there's a sharing of that growth between the money that is sent up to the MSO and growing the profitability, which leads to equity value enhancement, but also a portion of that finds its way back into the pockets on an annual basis of the physicians. Those producing the revenue, those seeing the patients, and really doing the work every day to maintain quality and outcomes and care for their communities and being rewarded for that on sort of an ongoing basis, I think is super important in the successful transactions.

(08:32):

And that's where you tend to see, pick your specialty, dermatology, ophthalmology, orthopedics, what have you, the haves and the have-nots that there are in each of those specialties platforms that have done better and platforms that have done worse. And almost every single time that you really sort of pick apart what's the issue internally for the ones that are not doing as well. It's a misalignment and a loss of faith with the doctors in the value of that equity. And therefore they're saying, "Well, why did I give up all this comp? I was hoping that my second bite was going to be substantial and meaningful additional liquidity event at some point." Now, I'm not motivated to come in every day. I'm certainly not motivated to see that extra patient if that's an opportunity for me.

(09:20):

And so that's why I say this, the alignment, I agree with you, Geoff, that the focus and the groups that are doing well and continue to do well, and as we look at even in our business deals that are potentially going to be new platforms, our goal is to try to set them up for success. And so we talk a lot with our clients about that and just say, "Look, I understand that if you're getting a multiple, you want to set your comp to zero and get it all right now and try to get some beneficial tax treatment on it if you can, and so on and so forth. But the reality is this is your legacy that you're leaving here. And if you want it to be successful and continue to be successful through multiple rounds of private equity and wherever it ends up, the prudent decision is to ensure that you still have a level of compensation going forward that's attractive.

(10:08):

Not just to your current group of physicians that exist at the time of the transaction, but to those who you might recruit in the future, right? Is there a meaningful spread between your average go-forward compensation of a physician within your group on a post-transaction post-scrape basis, is there a meaningful spread between that number and what any of these physicians might go get in the market from a health system, a smaller local group, et cetera, et cetera." And so for all those reasons, I think that's why I say I really agree with what you have to say there. It's really a matter of self-control and setting up the day-to-day, week to week, month to month incentives and aligning those with longer-term incentives where everybody benefits at a successful second bite or third bite. And that's how I think you create the successful and sustainable PPM platform today.

Geoff Cockrell (10:57):

Yeah, it became common knowledge or common expectation that yeah, a 30% scrape is probably the boundary of what is appropriate, but then everything became 30% and people weren't doing the reverse math of, okay, once you've done that, where does that land the go-forward compensation, and how does that compare to what other people choices that your existing doctors could make and alternatives in the market, but also your ability to attract and retain new talent. And if you start off with that misaligned from a current compensation perspective, it gets very difficult to keep people happy and attract new talent, and you start out in a hole that is hard to get out of.

John Tiedmann (11:39):

That's a conversation we have with every client upfront as we run that math, where are we setting the scrape? Let's divide that by the number of shareholders. Let's look at the market and see what the alternatives could be. Because yeah, to your point, it's not just the current group of people and can they go do better elsewhere, but how are you going to attract people. And if you find yourself in a situation where you need to pay more than the average partner is making to attract somebody, then all of a sudden you're sideways with the existing partner physicians because there's new folks coming in at higher levels, and the whole thing gets upside down pretty quick. So I think having that self-control is really the key to success in these models.

Geoff Cockrell (12:18):

And if you don't have that aligned, you're always going to suffer some retirements. I think coming out of COVID, retirements were higher than people expected just because the pressure on healthcare providers was pretty high. And plus a lot of these providers were outfitted with a lot of money in their pocket from the front-end deal. That combination of healthcare being a difficult place to work, coming out of COVID with some capital in their pocket, you ended up with higher retirement numbers, coupled with if you didn't have the calibrated correctly, you were going to have difficulty replacing them. And that became a toxic soup for a number of platforms.

John Tiedmann (12:55):

Sure. Yeah, absolutely.

Geoff Cockrell (12:57):

You made mention of income repair, obviously the idea is once you're in a bigger platform, you might have some improved contracting, you might be able to internalize ancillary service revenue, might be able to add other service lines, whether that's ASC revenue or other things. But the construct is that just by joining this bigger thing, your compensation apparatus should improve in some of these models. What has been from your perspective, the experience in that promise?

John Tiedmann (13:29):

Well, as with most things, I think that varies. I think you have the haves and the have-nots, but the people who are doing it well, the groups who are doing it well across specialties all have, I'll say they've proven the model. Meaning I think a lot of groups who underwrote this ability to get scale and negotiate with payers in a favorable way, I think that is probably the one that has the widest range of success. I think some groups have been able to do that well in some specialties and other groups who underwrote a scenario where that was going to be part of the income repair story, I think have struggled. And again, it depends on the state, depends on the payer, depends on the specialty. And that's why I think that was not as much of a foregone conclusion as maybe 10 years ago. And in the early days of PM investments, everybody sort of thought that that was going to be a slam dunk or a home run.

(14:24):

Where I see more success is certainly on the supply cost side, right? The economies of scale in using those to reduce your cost of goods sold and increase your gross margin, spread those costs over a wider base and leverage sort of a group purchasing, that has pretty common area of success as these things grow. The other area is really one of to spend or not to spend. Meaning where I see income repair being most successful is in those groups who are reinvesting in ancillaries, they're using the benefit of the MSO to help recruit and maybe fund guarantees for new physicians for a year or two. They're building surgery centers and outpatient sites of care where clearly all the volume is moving. But historically, you might have had a group that said, "Okay, I can build this surgery center," or, "I can build this sleep lab," or, "I can add an MRI or some sort of diagnostic equipment that's not inexpensive, and maybe my group is such that I've got younger doctors who are paying off loans.

(15:33):

I've got the mid-career guys who are gung-ho about growth, they're making good money and they can afford to make these investments." And then you've got some physicians approaching retirement who are saying, "All I want to do right now is fund as much into my retirement account as I can. I'm not going to see the benefit of this investment for very long anyway." And that dichotomy within the group is causing stagnation, right? No one can do anything because no one can agree on what they should do. And so in partnering with an MSO who can unlock some of that potential, whether it's to build or expand a surgery center, whether it's to make the investment in that diagnostic equipment or whatever it might be, you're enabling additional revenue to come into the practice.

(16:14):

You're enabling recruitment to happen in a way that is healthier and doesn't cost the physicians a direct hit to their personal income, which again, perpetuates the problems we talked about earlier. And as the practice grows, revenue grows, profitability grows, and if the alignment model is set up right, that's where you start to see some real opportunity for income repair to these physicians who may be scraped 20, 30, 40%, whatever it was in the initial transaction. And I think that the groups that are doing well with respect to income repair are getting almost full repair, if not better than full repair, right? The groups that are not doing well, the docs are still making whatever they reset their comp to in the initial transaction. And again, that's for any number of reasons, but most likely a lack of proper alignment.

Geoff Cockrell (17:09):

Another headwind that is starting to have some silver linings on it has been the dynamic around the model was always provider owned practice gets some scale and then they sell to a consolidator. That consolidator continues that pathway of acquiring other things, sells to a bigger private equity fund who sells to a bigger private equity fund. The question began to present of once you get really big, who's the next buyer and what's the strategy for that buyer? And it became a difficult question as public markets didn't appear to be a viable landing spot, and there aren't just bigger and bigger private equity funds. So the question of the ultimate buyer began to become its own constraint, which you layer into that difficulty in access to debt for acquisitions. On the big end of the market, you all of a sudden kind of hit a wall, which that is going to obviously trickle down into the whole model down below.

(18:08):

That presented a very real challenge to the overall consolidation model. But there have been some recent developments in that that have started to open that up. And I would be curious to get your thoughts on some of those, because some of them are, for the example, different kinds of strategic buyers, whether that is pharma companies that view certain sorts of practices as built-in distribution channels, whether that's oncology or other kind of high drug dispensing specialties or orthopedic type companies that might view certain kinds of practice. Obviously orthopedic type practices as potential product distribution chains, larger pharma or pharma services type companies, viewing certain kinds of practices as built-in clinical trial arenas. Just the emergence of new types of strategic buyers that were not really on most people's radar just a few years ago. How would you describe some of those emerging new buyers and their impact on the market?

John Tiedmann (19:08):

Yeah, I mean, that's one of the most interesting things that anybody in the PPM world is keeping an eye on right now is this emergence of the distributor as the buyer for some of these large platforms, right? You saw Cencora with Retina Consultants of America, Cardinal with GI Alliance. I mean, there's a number of these transactions that have happened over the last six to 12 months, and it's starting to answer the question you just described, which is where does all this end up, right? Previously, the two most logical penultimate exits for a large platform that has gone through numerous rounds of private equity and gotten to a certain size and scale is, one, the public markets, which the groups that have tried that have had varying degrees of success. And I think at some point, additional groups will continue to try that route as an exit path. And investment bankers much smarter than me, will help them figure that out. I think the other previously logical exit was payer, someone who's already publicly traded and has the scale and wherewithal to take on it a large acquisition of the scale that we're talking about.

(20:18):

And then as you mentioned most recently, the distributors. And to be very candid with you, I don't know that I can tell you with certainty what their strategy is. The distribution channel is the logical one, the R&D, and having sort of an embedded group of smart physicians under your umbrella to help think through problems and possibly develop new solutions, I think is another possibility and reason behind all this. But it is a new, large, typically publicly traded, financially stable group of buyers that can serve as an exit. If you're a large private equity firm with a platform that's approaching a hundred million of EBITDA, and you're wondering what to do with that, I think now we have another answer, at least in certain specialties, right? To your point, specialties who are not consumers of given supply product, implant drug won't make sense for every distributor, but certain specialties do, right? And so if it's orthopedics and it's one of the implant manufacturers, right?

(21:23):

Or if it's in the case of retina, that's a drug heavy specialty as we all know. And you mentioned oncology is another drug heavy specialty. So some of these I think are going to make sense for continued acquisition by the distributors. Now, the questions that I have in this whole model are, one, how does the behavior of these PPM platforms change once they're owned by these groups? Will the same buyer continue to consolidate and grow those PPM groups, or are we in sort of a testing the waters phase where there's only so many shots on goal? And until they figure out what their strategy is going to be, once Cardinal buys GI alliance, that's where it ends. That will I'm sure, evolve real time over the next 18 months, 24 months, we'll start to see how that's going to shake out. The other bigger question in terms of the success of these is how are they, operations of the PPM component going to change under the ownership of a distributor?

(22:19):

Meaning presumably the arrangements with the physicians are going to stay as they are. Presumably these are subsidiaries of these larger companies that continue to function and remember their roots as PPM platforms and that they serve the physicians who work with them. And hopefully those relationships continue to be fruitful and the physicians continue to be motivated under these new arrangements. I don't think anybody has that answer yet. I suspect a lot of these big distributors are going to take a hands-off approach to how they interact with the PPM subsidiary or however they have it set up from a corporate standpoint. And I suspect that if they do that, there will be continued success in the relationships with the physicians, their motivations, their incentives, and their continued caring for their communities.

Geoff Cockrell (23:16):

As you look at some of those large strategic buyers, bringing this conversation full circle, it also puts pressure on, "Okay, if there's not any more bites, any more apples, what then is left from an alignment perspective?" And some of the more interesting conversations I've been having with respect to either large, fully consolidated platforms or largely consolidated platforms, and even with smaller ones, is to rethinking some of the alignment mechanisms. And moving towards models that are less dependent on equity with compensation apparatuses that may kind of mimic some of the dynamics of equity in the sense of you could mirror a sub MSO model where you don't even have a sub MSO that's connected to one practice.

(24:04):

But you've recreated that in a comp apparatus that rather than having kind of income flowing from a particular practice to a subsidiary MSO that's owned partially by doctors and partially by the mothership, you can recreate those dynamics just in a comp apparatus, which that works. If it doesn't contemplate a second bite at the apple, I mean, you could, but usually they're more oriented towards current compensation. But that also becomes a workable model for, say, a large strategic buyer. You could recreate through compensation apparatuses a lot of the equity dynamics that you would do in say a sub MSO. I definitely see some evolution in the thinking of provider alignments with an eye towards building compensation apparatuses that can be durable through that sale to a larger strategic, which is an interesting evolution.

John Tiedmann (24:57):

Yeah, I suspect that's right.

Geoff Cockrell (24:58):

John, we've talked for quite a bit, a super interesting topic, and we could go on forever, but one last question. So we've got new emerging strategic buyers, you still have some headwind elements that might be mitigating, whether that is the cost of capital coming down a bit or combining that with more rationalized valuation expectations that headwind can mitigate, labor market headwinds can mitigate. If you kind of add all those pieces up, are you bullish or bearish in the next 12 to 18 months on the consolidation market for PPMs?

John Tiedmann (25:32):

I'm bullish. I like where things are going. I like that groups had sort of the last couple of years to reevaluate and look internally and understand what is and isn't working and fix some of those things. And I think that many of those groups have now emerged stronger for it. And I suspect that as the market continues to open up, you'll see some of the platforms start to trade and achieve some of those second bites that we've talked about. And that will become a bit of a self-fulfilling prophecy, both with regard to the private equity community and their interest in the space and continuing to see hopefully successful exits. But also with respect to the physician community and those who haven't yet done a transaction, I think they've been waiting on the sidelines to see how some of this plays out. And so for all those reasons, I think that the next several years in the PPM space will be strong and fruitful for all involved.

Geoff Cockrell (26:29):

I think that's right. And one thing that that probably doesn't mean is that a more robust market is not necessarily going to correct challenges or that surround purchases that say a platform made three years ago at super high valuations. To the extent that some of these platforms have balance sheet problems, those are difficult to operationally correct, but those also tend to work themselves out over time. So if overall market starts to re-accumulate some tailwinds, I agree that the whole process of providers selling to platforms and then that consolidating is going to reopen. So I agree, I'm bullish on the future in this as well. Even if there are some rocky investments or rocky steps along the way, I think the overall tailwinds will overcome the headwinds. And so we'll see what 2025 bears out. But John, thanks for spending a little time with me. This was a ton of fun.

John Tiedmann (27:25):

Yeah, Geoff, likewise, thanks so much for having me.

Voice over (27:31):

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