McGuireWoods

THE CORNER SERIES

Episode 127: ‘Medicine is Local’: Partnering With Emergency Departments, With Kevin Baker

Episode Summary

“Our big mantra is: ‘Medicine is local,’ ” says Kevin Baker, who partners with emergency medicine groups across the United States in his role as director of development at Emergency Care Partners.

In this conversation with McGuireWoods partner and host Geoff Cockrell, Kevin lays out the landscape of the U.S. emergency department sector, where about a third of hospitals now in-source their physicians. He unpacks the major headwinds facing emergency department operators: patient boarding, NSA fallout, declining reimbursement and EMTALA’s built-in bad debt burden.

Tune in to hear what he describes as the biggest competition Emergency Care Partners faced — it may surprise you.

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 (00:21):
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 deal makers and thought leaders at the intersection of healthcare and private equity. Today, I'm joined by Kevin Baker. He's a director of development at Emergency Care Partners. And before we dive into some discussion of that particular sector, Kevin, if you could give a little introduction of yourself and Emergency Care Partners.

Kevin Baker (00:47):
Thanks, Geoff. I appreciate you having me on. I've been with Emergency Care Partners now for about a year and a half, as I joined in July of 2024. I have the great privilege of serving on our business development team here at ECP, where I focus on supporting the national growth objectives of the company. Place where I operate the most right now is in new physician practice partnerships, where I connect with emergency medicine partners across the U.S., to try and better understand some of their pain points with managing their own practice, and there sure are a lot. And if we have the right mutual fit, we go down a path of formally partnering together. I've kind of been in the multi-site healthcare services space now for about a decade. And it's just been a great place to learn and support our healthcare ecosystem. And I've grown quite passionate about supporting operators in this space.

Geoff Cockrell (01:38):
In the landscape that you encounter, how often are the ER docs employed by the hospital, versus employed by a independent physician group?

Kevin Baker (01:48):
Yeah, so that's a great question. And one that where the industry has kind of shifted and there's been some change in the last three to five years, I'd say, because of a few different catalysts. But I think, today there's north of 5,000 emergency departments across the U.S., roughly. And I would say, about a third, just maybe north of a third, insource or employ their emergency medicine physicians. And that's a trend that's kind of shifted for a few different reasons. Obviously, the No Surprises Act and a few other big changes with some of the large players like APP and some other Chapter 11 reorganizations within the space, has kind of shifted some of that, where a lot of hospital CEOs decided to bring that in house, when those big industry events happened. So, it's kind of shifted a little bit more on the insourcing kind of employed side.

Geoff Cockrell (02:50):
And so, when you're out kind of talking to independent physician groups, is that often a competitive process with the local health system or what does that dynamic look like?

Kevin Baker (03:03):
Yeah. So, we're kind of getting into more of our organic growth team that focuses on that at ECP. But yes, typically what happens is, maybe there's a broad RFP process that happens with hospital CEOs, or maybe it's more of a narrowed focus RFP, where they're only reaching out to maybe two or three ED providers. But we participate in these broad RFPs and then more kind of focused RFPs. But our organic team does a really good job of building relationships with hospital CEOs. I focus more of my time on connecting with physician partners, CEOs of independent emergency medicine practices.

Geoff Cockrell (03:44):

And what's the typical size and scale? Is that a somewhat consolidated sector, in that there are very small groups, mid-size groups, larger groups, or is it pretty diffuse with a lot of small groups at local hospital levels?

Kevin Baker (04:00):
Yeah, it's a combination. I mean, we see quite a lot of groups that are just single site emergency department groups all over the U.S. that have been operating at a high clinical quality standard for 30, 40 years, and they've just built a great reputation. Unfortunately, the single site ED operator is kind of under attack. There's a lot of larger players out there that are looking to kind of disrupt the space a little bit. Obviously, everyone's looking to grow. ECP is in that bucket. And our model is very unique though, in the sense that, when we partner with someone, we keep the local brand, we keep the local identity. Our big mantra is, medicine is local. And so, the type of medicine that occurs in New York City is very different than what happens in Boston. So, retaining the brand, retaining the local leadership, is everything in the emergency medicine space.

(04:55):
So, there's a lot of single site ED operators, but then you've got your larger multi-site players, that maybe are more regional focused and they've grown pretty tremendously within a larger health system partner and they might have 10 to 12 emergency departments. And so, you've got a lot of regional players out in the marketplace as well. And then you've got the large, for lack of a better word, contract management groups, that are national, in 30 plus states, they offer multiple service lines as well. So, outside of emergency medicine, they might offer hospitalists or anesthesia, radiology, ICU. It's important to note, ECP is really just focused on emergency medicine today.

Geoff Cockrell (05:40):
As you look at the market from kind of a growth perspective, how would you segment the market from the perspective of population density? Meaning, kind of urban, suburban, rural markets, how are they different and what are the opportunities and risks for a company like you in those different segments?

Kevin Baker (05:58):
Yeah. Yeah, no, it's a great question. There are over 140 million ED visits annually across the U.S., especially with all the big news around value-based care and trying to keep folks out of the emergency department. ER visits have probably grown by a modest 1, 1.5% CAGR, for maybe the last 10, 20 years. And so, emergency departments really still play a very large role. And large metro markets, NFL markets, tend to be a really great place to be an ED operator, for a few different reasons.

(06:32):
One, is recruiting. In this space, 80%, sometimes north of that of your revenue, is tied to labor costs. And so, your ability to recruit high quality, board certified, board eligible physicians and high quality

APPs, is really everything in this business, to be able to manage your costs, given the high percentage of revenue that labor is.

(06:56):
And so, large NFL markets and large metro markets really have that benefit of being able to recruit. A lot of times there's some big residency programs in those markets. And so, it really creates a great funnel to recruit high quality providers. Interestingly, on the rural side, we've seen a lot of activity on the rural healthcare here in the U.S., a lot of assets and a lot of great companies that are looking for some transition and some succession planning that operate in that space. And I have a few suspicions about why that is, but I think some of the legislative changes that are now coming on board, with Medicaid dollars and additional rural healthcare dollars being poured into that space, we're seeing a lot of activity in the rural part of medicine here across the U.S.
(07:44):
And it's a similar struggle in rural as it is the same consideration with large cities and large markets. It can be difficult to recruit high quality providers in those rural markets, and access to emergency medicine can also be a real big challenge for patients in those markets as well. And ECP, while the majority of our emergency departments are, I would say, probably in larger metro markets, we've got 10 to 12 critical access hospitals across our portfolio, that are really focused on serving the rural population and the needs of those patients.

Geoff Cockrell (08:19):
One of the questions I often ask folks in different sectors is, to think about both your own company and the sector in which you work, through the prism of how it fits into the triple policy aims of healthcare, namely to improving outcomes, improving access and controlling system cost. How does ER staffing models, how do they fit within those triple aims in general, and how does your company in particular, address those aims?

Kevin Baker (08:54):
Yeah, no, great question. I mean, clinical quality, first and foremost, is everything for us. And so, if we're working with high quality providers, that means everything to our patients, to our hospital administrators, to our leadership. It's really everything. And people often disconnect quality maybe from some financial outcomes. And I really like to view them as kind of one and the same. If you have high quality, for example, then you have a very low likelihood maybe, or a lower likelihood of being subject to medical malpractice lawsuits, for example. And so, cleaner claim history that you have on medical malpractice, can really impact you beneficially from a bottom line perspective and managing your professional liability and medical malpractice costs. And ECP, actually, we launched a captive policy last year to help manage those medical malpractice costs for our group as well, which has been a big win for us.

(09:53):
From a cost perspective, there's a few different angles, right? From the payer's perspective, emergency department tends to be very costly. And so, if you're one of the BUCA payers out there, certainly having your members visit the ER is very costly. And there have been a few attempts at value-based care, specifically in the emergency medicine space, but I think it's probably more prevalent in other specialties across healthcare, like gastroenterology or nephrology, orthopedics, cardiovascular. Those are the specialties where you tend to see a lot more activity and a lot more focus on value-based care initiatives. ED providers are just there to triage the patient and make sure that they're okay and treat them to the best of their ability and then move on to the next patient. It's a very fast-paced moving environment. So, there's not much movement in terms of value-based care or bending the cost curve, that I've seen in my year and a half here in the emergency medicine space.

(10:52):
And then from an access perspective, that's an area that will have some movement here, I think, with some of the rural healthcare dollars that are being poured into the space. But the other thing that I will point out is, I think we've seen an increased prevalence in freestanding EDs. So, a lot of health systems are kind of realizing the benefit of having these satellite emergency departments within their market, to really increase their catchment zone and to capture patients within the larger network and then redirect them if they need to, depending on their clinical situation, to a larger acute care hospital so they can better triage the patient.

Geoff Cockrell (11:32):
One of the questions I often ask folks as well is, thinking about kind of your model through the prism of, what stage of consolidation is that sector in? Some sectors are in early innings, some are in late innings. And then the secondary question is, once platforms within this sector get to be of material scale, let's say 200 million of EBITDA, the question often arises, who could be a purchaser of that and what would they do with that? How do you think about the consolidation level in the sector in general and who would buy a big thing and what would they do with it?

Kevin Baker (12:12):
Yeah. So, as you know, I mean, the physician practice management space is not a novel idea. There were publicly traded PPM businesses in the late '90s, early 2000s, that were doing something very similar to what a lot of the other players are doing here in this space. And so, I think we've had a resurgence in kind of the MSO and the PPM space probably within the last decade, I'd say. And to your point, what you alluded to, there are some specialties where consolidation has been occurring longer than others. And so, emergency medicine is definitely one where I think we are not in the early innings necessarily of consolidation. There's been a lot of M&A activity in this space for quite some time, with some of the larger players really leading the charge.

(13:04):
ECP is a relatively newer entrant in this space, being founded just in 2018. And we've formally partnered with groups to the tune of about one per year, and we're really selective in who we decide to partner with. We got to make sure they've got the right clinical quality metrics, got to make sure that they're strong financially, but these are practices that are looking for some additional support. And I think there's much more runway to go for partnering with high quality emergency medicine groups here in our space.

(13:36):
And then, when you start to get to a certain size threshold as well, there's certain considerations that you have to come into play as well. And so, I think for us, we are single specialty emergency medicine predominantly today. And so, I think, as we continue to grow, there's significant opportunities with expanding within our existing health system footprint and then even expanding into new service lines potentially. So, I think those are some additional growth vectors that we can expect here over the next five, seven years.

Geoff Cockrell (14:09):
Every sector is a combination of tailwinds that are pushing the sector forward and headwinds that are kind of pushing the other direction. What would you describe as the tailwinds from where you sit in ED staffing and what are some of the headwinds?

Kevin Baker (14:26):
Yeah. So, I'll start with some of the headwinds first. I'd say there's kind of maybe three big headwind trends that I see. I think the first is boarding. So, like I mentioned earlier, there's about 140 million emergency department visits each year in the U.S. And so, you can imagine how much stress this demand puts on the system. EDs nationwide are very much overwhelmed with patients waiting for inpatient beds. And lots of times, this is an issue of bottlenecks within the four walls of the hospital, where admitted patients can't get discharged quickly enough, but ultimately this is a very complex multifactorial issue that isn't easy to solve.

(15:05):
Second is, there are still some fallouts from NSA and the Federal No Surprises Act really changed the out-of-network game for many providers in our industry. And there have been a lot of documented flaws with the implementation of the NSA, but this has real implications on independent emergency medicine groups. And so, we've seen evidence of payers systematically underpaying or delaying payment that is rightfully rewarded to emergency medicine groups and it's just not right.

(15:37):
And then lastly, I think negative reimbursement trends is the other big negative headwind that I'd say. And this is probably old news to most people that are familiar with the healthcare sector, but I know

the CMS rule for 2026 came out. And while we actually did see maybe a slight uptick this year, that's probably the exception to the rule. And so, I think, largely we have seen professional fee rates go down into the right for our level one to level five visits in the ER space.

(16:07):
Another thing that's pretty unique in the emergency medicine specialty is a federally unfunded mandate called EMTALA, which basically says, you as an ER doc, have to see every patient that walks through the ED, regardless of their ability to pay or their demographic. And so, on average, I'd say, one out of every $5 of money that's owed to an ER group, goes uncollectible. 20% just goes to bad debt. And so, in this specialty, every nickel, every penny really matters. And so, having a partner that operates on a larger scale, like ECP, that really understands these nuances and can support the RCM process, can really go a long way.

(16:47):
And then, on the tailwinds side of things, I would say, it's from a hospital operator perspective, it can be really difficult to manage an emergency medicine practice internally. And so, I think outsourcing the ED to a trusted provider like ECP, really, really continues to be what we've seen as the focus area in this space. And there's really a tremendous amount of high quality providers and operators in this industry. And I would say, groups that are really well-equipped and have the infrastructure, have invested in infrastructure, are really capitalizing on some of those fallouts from NSA that I've mentioned in the past.

(17:30):
And so, at ECP, we're largely an, in-network shop. But in the event that we need to kind of get fair and equitable in-network rates, we will certainly leverage independent dispute resolution in order to get to that role. So, I continue to think that, yes, there are a lot of independent ER groups out there. A lot of those partners are aging, looking for some succession planning, and a larger national group that has a little bit more infrastructure is likely the future of where this space will go.

Geoff Cockrell (18:02):
Looking forward into 2026, how would you describe how active you think the M&A market's going to be? Historically, there's been some disconnect between kind of bid-ask expectations on multiple pricing and other things that have made the kind of add-on acquisition market challenging or in some sectors, completely stop. What does the market look like for M&A activity in ED staffing for 26, from where you sit?

Kevin Baker (18:29):
Yeah, I think it's a great question. I think it's a bit of a mixed bag. In terms of overall number of buyers in this space, I think we're somewhat limited. So, some of the larger players, some of the maybe larger well capitalized players in this space, are still kind of rebounding from some large industry

events that kind of shaped our space, namely NSA and maybe some high profile bankruptcies and restructurings. And I think a lot of the larger players, maybe four or five years ago, really made some riskier acquisitions as well and maybe over-leveraged themselves and they're still kind of working through some of that. ECP is very much well capitalized. We actually just completed a recapitalization last year, where we got some additional capital on our balance sheet to go and complete more M&A in this space. And so, from our perspective, I think there are certainly fewer buyers than there were maybe five years ago, but the seriousness of buyers today, I think are very real, and I think ECP is one of them.

(19:33):
I think there are a lot of things that are pushing independent ER groups to explore their options. And the biggest competition that we come up against is really status quo. They don't want to do anything, they want to continue as is, and they've been very successful for the last 20, 30 years. So, competing against status quo is really, I think, the biggest factor for us. But there are still a lot of groups out there that we talk to, that are like, Hey, we're aging, we're looking to get some liquidity for the practice that, frankly, we put a lot of sweat equity in for the last 20 to 30 years and a partnership with ECP is really one way to maximize that liquidity. A lot of groups really have very inadequate ways to provide liquidity to their shareholders.

(20:21):
A lot of times, practices and partners, they end up going into retirement and they end up just getting A/R value for the practice that they built over 20, 30 years. And so, all of the equity that they've built up over these years, is very limited in that regard. And then we also see hospital systems looking to bring things in house as well. And so, if a hospital really does decide to make that transition from outsourcing to insourcing, potentially this outsourced independent ER group could theoretically just lose their contract and just become a hospital employee and walk away with nothing for the practice that they've built. And so, those kind of things happen a little less frequently, but they're very real realities that a lot of independent groups are facing. What we always say is, you're only as strong as the term of your ED contract.

(21:12):
And as long as you continue to provide good clinical quality, you have the resources to support the growth of the hospital and the health system provider, then you should be okay, but there's always a risk.

Geoff Cockrell (21:24):
Kevin, we could talk about this for quite a while, but I think we'll call it a wrap there. Yeah, you certainly work at a great company and it's a super interesting sector and looking forward to seeing what 2026 brings. But, thanks a ton for joining me, this has been a lot of fun.

Kevin Baker (21:38):
Thank you, Geoff, for having me on. Appreciate it.

Voice Over (21:44):
Thank you for joining us on this installment of The Corner Series. To learn more about today's discussion, please email host, Geoff Cockrell at gcockrell@mcguirewoods.com. We look forward to hearing from you.

(21:57):