McGuireWoods

Episode 128: Building a Gastroenterology Program That's 'Second to None,' With Matt Devine

Episode Summary

How did Allied Digestive Health build a gastroenterology program that's "second to none" with roughly 200 gastroenterologists across New York and New Jersey? CEO Matt Devine unpacks the strategies, such as investing in technology and having one EMR across the platform that's world class.

"If we're just going out and getting larger, that's nice and that's admirable. But what we really need to do at the end of the day is improve outcomes. And that's what our doctors take pride in every day," he tells McGuireWoods partner and host Geoff Cockrell.

Tune in for Matt's insights about what Geoff calls the "triple aims" in healthcare: improving outcomes, improving access and controlling system cost.

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 (00:19):
Thank you for joining another episode of The Corner Series. I'm your host, Geoff Cockrell, 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.

(00:31):
Today, I'm joined by Matt Devine, the CEO of Allied Digestive Health. Allied Digestive Health is one of the larger platforms in digestive healthcare, and we're going to talk about a lot of different kind of

challenges and opportunities in that sector. But Matt, if you could kind of introduce yourself and Allied before we start, that would be super helpful.

Matt Devine (00:52):
Thank you, Geoff. As you indicated, my name is Matt Devine. I'm the CEO of Allied Digestive Health. Allied Digestive Health primarily is in New York and New Jersey. That's our two primary markets, and that's where we focused. In New Jersey, we're about 130 gastroenterologists. And in New York, we're approximately 70 gastroenterologists. In New Jersey, we cover pretty much the entire state.

(01:14):
And in New York, we cover all five boroughs and we're in Albany as well as Rochester, New York. When I talk about physicians working for us, that was 200 gastroenterologists, and we have approximately another hundred anesthesiologists, and then we have about 10 pathologists as well that all are a part of Allied Digestive Health.

Geoff Cockrell (01:33):
Matt, there was a time when kind of doing well in provider consolidation was almost easy. The tailwinds were just numerous. You could arbitrage the multiple split on small things versus larger things. You could leverage for close to free. And those dynamics were often independent of kind of improvements that you could make, which those were available as well.

(02:00):
Some of those dynamics have changed. The market for kind of acquiring things has gotten more difficult. Debt is not free anymore. And so, now you have to kind of build businesses that are improving and growing organically. How do you guys at Allied Health think about growth from where you sit today?

Matt Devine (02:19):
You're correct in this statement that there was certain things that were relatively easy. We had managed care contracting, those kind of things that were basic to consolidation. So you had efficiencies that you were looking for. In today's market, you have to really invest in technology, I think. So that's significant. You have to know how to create value for physicians that wasn't there previously. You need to be able to create levers where physicians, because of our size, are able to kind of see other synergies than traditionally they've seen.

(02:54):
So for instance, being able to provide anesthesia services to our gastroenterologists is a way to generate better outcomes where we're doing the anesthesia. Pathology, another way to generate better outcomes, better patient care. These type of things are really value-added services that weren't

in place a lot of times when we acquired these practices. I think also investment in technology is a must-have going forward. It really improves the overall efficiency of the practices.

(03:28):
We do things such as selling our de-identified patient data that really allows pharmaceutical companies, for instance, to really focus on generating better outcomes for patients more long-term down the road. The bar has been definitely raised, and it continues to be raised. The challenges in physician services as more patients are bearing more of the burden of the cost, we have to up our game to allow us to really provide better services than these physicians could get on a smaller scale. So I think, overall, it's good for physicians. It's good for patient care.

Geoff Cockrell (04:08):
The dynamics of kind of being able to introduce opportunities with ancillary services like pathology or other service lines like anesthesia or ASCs, I can certainly see that scale and capital are often barriers to smaller practices being able to dip into those arenas. Where's the line do you think of size where that becomes an opportunity? And does most of your kind of growth through acquisitions happen below that line?

Matt Devine (04:39):
I'd say most of our acquisitions are below that line. But a lot of times we can introduce things to even large practices, results in better patient care and better opportunities to provide synergy to those existing incumbent groups. So to me, obviously in GI, it's interesting. The groups are fairly small. There's some large GI groups. And in the GI world, a group of 10 physicians is actually large. So a lot of times they haven't fully developed all the ancillary services.

(05:14):
So for instance, in New Jersey here, us and our private equity partner, Assured Healthcare Partners, built a brand new lab that has plenty of capacity. And so to us, that's another driver of income to the physicians, but it's also provides better patient care. And our turnaround times in these labs are typically two to three days max. So we can get that to the patient, our outcomes, if you will, and better influence the outcomes in a quicker fashion than what's traditionally been the case.

(05:47):
In New York, we built a brand new lab as well. And again, providing better patient care to our patients. So big upside to physicians. And really, whether it's a one doc practice or 10 doc practice, the opportunity is still there because these are significant investments that we're making that any small scale group just wouldn't have the capital to do, would be economic for it. So labs are often, the economics of the lab, is the more volume you drive through, obviously the better your income and your contribution is going to be.

Geoff Cockrell (06:17):
You're touching on some topics that I want to expound upon a little bit. And coming at this question from the direction of when I'm talking to folks that are kind of at the intersection of healthcare and private equity, that intersection often gets punched at a lot with respect to whether or not those platforms are contributing to what are the triple aims in healthcare from a policy perspective of, A, improving outcomes, B, improving access, and C, controlling system cost.

(06:49):
How would you describe Allied Digestive Health's kind of contributions on those three aims? Because I'm a big believer that private equity backed platforms actually have the ability to contribute to all of them, and that the shots that they take are misplaced. But I'd love to hear your assessment of how you contribute to access, outcomes, and controlling system cost.

Matt Devine (07:09):
I think from a system cost standpoint and a quality standpoint, I think those are central to what our mission is. So I think we've been able to offer our patients better outcomes of why. Well, we've invested in the technology and we have a unified platform that we can compare outcomes across the platform. So we don't have five different EMRs or three different EMRs. We can take our data and compare outcomes. So I think from a private equity standpoint, we have a quality program here that, in my opinion, is second to none in the world of gastroenterology. We're constantly looking at outcomes and how we can have our physicians better impact outcomes long-term. And so to me, if we're just going out and getting larger, that's nice and that's admirable. But what we really need to do at the end of the day is improve outcomes.

(08:03):
And that's what our doctors take pride in every day. And I think when we go out and acquire practices, we're constantly looking at how these physicians compare versus our kind of group year. So we can look at their outcomes and say, "Can we influence these outcomes? Can we get better results?" I think when you have one EMR, and again, you can kind of offer these physicians one EMR that's world-class, that's really had a huge investment in it, that's good for patients. We're using technology today that a single practice group would not be able to afford, would not know about what's out there. And I feel that that's favorable for outcomes, favorable for expense, lowering the cost of care. I think also we've been able to contract with payers. And our model is completely... We're, for the most part, almost 100% I'd say on par, if you will. We're not non-par. We have contracts with every payer out there.

(09:02):
So again, access to care, but across all the payers. So there's very few payers in the whole system where we're not contracted. Okay, so again, offering our patients whole plethora of payers that typically some groups might not be par with, maybe par with. We see Medicaid patients. We see

Medicare patients, obviously. And so, very proud of the fact that we're contracted with all the payers out there and provides our patients with universal acceptance of their insurance for the most part. To me, you could say, is that good or bad? But I mean, I think it's a tremendous thing that we do and it's favorable. So again, I think we're not a high cost operator. We work with our payers to make sure that we're not non-par, that we are offering low cost care to the patient, but very high quality care.

Geoff Cockrell (09:53):
Another way that, I think, doesn't get enough focus for companies like Allied is the ability to kind of move care to the less expensive venue. And one of the areas that I think needs to come out more in kind of general perception is private equity backed companies often get chipped at because they're usually able to negotiate advantageous reimbursement rates or partner with other kind of management companies that are able to lean into ASC reimbursement rates.

(10:26):
But what gets lost in that calculus is not the rates themselves, but the question of compared to what? And the compared to what is often procedures being done in the far away most expensive place, which is at the hospital. How do you see the impact of larger private equity backed platforms in moving patients into the most cost-effective venue?

Matt Devine (10:48):
Yeah, that's definitely true. I mean, to us, most of our services are outpatient focused. We certainly cover hospitals, but the vast majority of the care that we provide is done in an outpatient setting. As you know, the outpatient setting is significantly cheaper than the hospital setting. So to us, as patients become more responsible for managing the cost of the service, we are the low cost operator out there. And it's not close, obviously. The hospital rates are significantly higher than what we're getting in an outpatient setting. And as healthcare becomes more expensive for the consumer, it's very important that the choices they make go to low cost, high quality providers. And I think our physicians offer that service.

(11:35):
And again, it's important that we offer the whole range of services to the patient, so that you're not going to go to our services and be like, "Well, we're non-contracted on the anesthesia side," or "We're non-contracted on..." We're contracted with all the payers in trying to provide high quality, low cost care to them. So again, significantly reduced cost to the consumer as a result of being in an outpatient setting. And I think the payers understand that as well. So the payers are looking for alternatives to the hospital as a low cost provider going forward. So that's a big value prop to our patients.

Geoff Cockrell (12:16):
That dynamic with location of care can posit different sorts of relationships with local health systems. Sometimes they are friends, sometimes they're enemies, sometimes they're frenemies. How do you think about partnering with health systems versus directly competing with them? It's probably a spectrum that is kind of very locally dependent on some of the dynamics on the ground, but how do you think about your relationship with the health systems?

Matt Devine (12:46):
So in New York and New Jersey, we have very good relationships with the hospitals. For the most part, if we're seeing patients in a hospital setting, there's a reason why that patient is in the hospital. It's something. It's emergent care. We're seeing patients that are much sicker than we would see in an outpatient setting. So I don't look at it as that we really compete with the hospitals. I look at it more like the hospitals have... They're providing service to everybody that comes through their door, if you will, in the emergency room, whatever it might be.

(13:12):
I look at us as, the vast majority of our patients have some chronic disease or they're getting a colonoscopy, what have you. So we're not really competitors. I don't see us as frenemies either. I see it as we provide a service to outpatients that really is quite different than what the hospital's focus is on. So we have agreements with many of our hospital partners, very good relationships with almost every hospital that I know of that we provide services, but I don't see us as competing with them. It's a very different patient population that we're seeing than the hospital's seeing for the most part.

Geoff Cockrell (13:49):
When you think about alignment with providers, I can see the presentation to a smaller practice where what you provide is kind of a number of levers, whether that is kind of access to an ASC, anesthesia services, pathology services. I can see all those benefit for a smaller independent practice. But once a group is a part of your system, kind of maintaining provider alignment has been, in my experience, a difficult needle to thread over time.

(14:20):
When you think about kind of provider alignment in your own organization or looking at others that you see, what are the drivers of success in kind of ongoing provider alignment? And what do you think are some of the drivers of non-success in that alignment?

Matt Devine (14:38):
Good question. For our standpoint, Allied Digestive Health is about 50% owned by physicians and 50% owned by the private equity firm. Those are rough numbers. So the success of Allied Digestive is obviously dependent upon physicians owning a large portion of the equity of the company. So they're very much aligned in the success of the company. They're all investors in Allied. So we feel

that we have good alignment with our partners. And our partners also, our physician partners, typically like in New Jersey, they own a portion of the Ambulatory Surgery Center.

(15:17):
So typically, they have a minority interest in the ASC that we don't own. And in New York, we have some ASC relationships, more of them are OBS relationships. But again, we feel like we have great alignment because of their ownership interest in the Allied Digestive Health of almost 50%. So we have very low turnover at Allied. And our goal here is, that Allied Digestive Health, the MSO, is to provide services to the physicians. So we work for the physicians. We're trying to create value for the physicians going forward. And our job here is to support the physicians as they practice care for their patients.

Geoff Cockrell (15:57):
One of the ways that I think about alignment with providers is kind of through the economic prism of to what do their incentives attach. And there are different approaches to that. There's equity approaches with some groups having ownership at a topco level. Some do equity ownership at kind of a sublevel that might connect to just a state or even smaller subset of the business. Those smaller subset economics through ownership may be current cashflow, they may not be current cashflow.

(16:30):
There is kind of economic connection to ASC ownership, which you alluded to. And then, there's also kind of more elaborate compensation apparatuses that can connect more of their economics to kind of profitability at more local levels. How do you think about the split between economic attachment to the overall organization versus economic attachment more locally on something they can impact? And how have you found some success in navigating that?

Matt Devine (16:57):
So from our standpoint, we have what we call care centers. So each care center is typically five doctors or more in a care center. And that care center has their own way of compensating the physicians. So let's say it's five physicians. They might be partly what we typically refer to as eat what you kill model. You're compensated basically based on the work that you put into the practice, if you will. You know what I mean? The number of patients seen and things like that.

(17:24):
And then there's other ones, models where it's the five physicians or more would typically share 50% of their income evenly, and then 50% based on productivity. So the model is very locally centric. Okay? Very focused on the work that they do. And so, the way they're compensated is typically at the very local level in these individual care centers with their own model. And typically, there's like three models tied to productivity, eat what you kill, or it could be just to share everything equally model. So

all the proceeds, if you will, are very much local. So they're not compensated at a higher level that says based upon what the overall organization does. It's very locally centric.

Geoff Cockrell (18:10):
Super helpful. Switching to kind of growth ideas. The M&A market for kind of acquiring smaller practice has been bouncy for the last close to two years. And there were a lot of reasons for that bounciness. Some of that was kind of credit availability. A lot of platforms ran out of delayed draw access to acquisition capital through their credit facilities.

(18:36):
There were labor pressures that made kind of those expenditures difficult. And then, the bid ask between what sellers were wanting versus what buyers were willing to pay just got misaligned. What does the kind of smaller acquisition M&A market look like to your eye now versus, let's say, six or 12 months ago?

Matt Devine (18:59):
I think the smaller practices out there, it's still fairly active. I think the smaller practices, sometimes we can realize synergies day one that allow us to flex the multiples down. The multiples that I see out there, they haven't moved that much in the last two to three years. For the most part, they're pretty consistent in the ask.

(19:22):
For us, the challenge is to be able to realize some level of productivity increase through technology or service offerings. Not making physicians work harder, just work smarter, better technology, things like that where I can flex the multiples down. So these smaller practices, I don't really see the multiples being increased over the last couple of years. It's pretty consistent what they're looking to achieve.

Geoff Cockrell (19:47):
There's only a handful of large GI practices out there, and it seems unlikely that list would get added to substantially at this point. And kind of continuing to kind of grow through acquisitions of smaller things is available to everybody. But where does the future go for these larger platforms?

(20:09):
Is there always a bigger financial buyer? Optum buy everything. Is there a pathway for going public? Is there a pathways for kind of landing with large institutional sovereign funds that are viewing investment kind of like exposure to public markets that are just stable growth? Where does the future go for this overall market from where you sit?

Matt Devine (20:35):
Through that right now, I think that there's a lot of different models that are in play. And certainly there's strategics out there that are looking at purchasing GI platforms. There's hospital groups that are looking at purchasing GI platforms. There's private equity that's still out there looking to purchase GI platforms. So I don't think anybody has the one answer to that question. I think time will tell. But certainly, there appears to be a rather robust market for GI platforms out there, and only time will tell.

Geoff Cockrell (21:10):
Absolutely. That's what makes this exciting. Matt, I really appreciate you spending a little time with us. You've built a fantastic company. I have a ton of respect for you all, and really appreciate you coming onto the show.

Matt Devine (21:22):
Thanks, Geoff. I appreciate it and I appreciate your time here today.

Voice Over (21:27):
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.

(21:40):
This series was recorded and is being made available by McGuireWoods for informational purposes only. By accessing this series, you acknowledge that McGuireWoods makes no warranty, guarantee, or representation as to the accuracy or sufficiency of the information featured in this installment.

(21:55):
The views, information, or opinions expressed are solely those of the individuals involved and do not necessarily reflect those of McGuireWoods. This series should not be used as a substitute for competent legal advice from a licensed professional attorney in your state and should not be construed as an offer to make or consider any investment or course of action.