McGuireWoods



Episode 144: The Post-Close Playbook for Physician Practice Platforms, With Clark Bosslet and Louis Clark

Episode Summary

Physician practice platforms often run lean, leaving little to cut after a private equity deal. McGuireWoods partner and host Geoff Cockrell explores where value lies with ECG Management Consultants experts Louis Oster, a principal in its Medical Group Optimization division, and partner Clark Bosslet.

For Louis, the path forward runs through revenue cycle improvements, provider productivity and organic growth. While Louis favors business-unit phantom equity to keep physicians invested in the performance of their own practices, Clark cautions against cutting physician pay at closing with promises to restore it later. Tune in to learn why steep pay cuts can undermine recruiting and how platforms can balance centralized control with local autonomy.

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 (00:20):

Thank you for joining another episode of The Corner Series. I'm your host, Geoff Cockrell. 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 have two guests, Louis Oster, who's a principal, and Clark Bosslet, a partner at ECG Management Consultants, one of the leading management consulting groups in healthcare companies.

(00:41):

Clark, if you could introduce ECG, and then Louis, also introduce yourself. We'll jump into some discussions.

Clark Bosslet (00:47):

Absolutely. First of all, thank you so much. I'm really excited to be a guest with you today. I've listened to a lot of your prior work and excited to join you here. So my name's Clark Bosslet, I've been a partner, I've been with ECG now for over 15 years, partner in our D.C. office. Started my healthcare background back in Texas, and with a focus on pediatrics, I now spend a lot of time focused on various hospital-based specialties.

(01:08):

ECG is the longest tenured healthcare specific consulting firm in the country. So when I got into my job, I knew I wanted to be focused on healthcare exclusively. Our history is largely in academic medicine, but we do a lot of work with physician enterprise planning, payer strategy, and we've expanded into service line and enterprise strategy, M&A, inpatient operations, and a bunch of tech enabled solutions, because you can't be in healthcare right now without talking about that. So, that's the area that ECG tends to work within.

Louis Oster (01:38):

Hi, Geoff, I'm Louis Oster. I'm a principal at ECG in our Medical Group Optimization Division. I'm based out of our Chicago office. I've spent a number of years working in a physician enterprise, variety of organizations, including investment backed medical practices, and now on the consulting side. I continue to work with the physician enterprise, including private equity. Oftentimes where I'm working is post-transaction value creation or value capture, focused on improving operations to drive cash flow.

Geoff Cockrell (02:05):

Louis, let's start with you. So when a private equity fund acquires a platform and you all are going to be present to create that value enhancement, when you walk in, what typically are the deficiencies that you immediately recognize you're going to need to be addressing?

Louis Oster (02:19):

Yeah, I love that question, because there's not one deficiency. Oftentimes, you're seeing multiple deficiencies. You can usually count on something in revenue cycle, whether it's front end registration, charge capture, all the way to backend charge posting. So, revenue cycle is a hot topic.

(02:33):

I think one thing too is maximizing provider productivity. Understanding the obligations of the providers in terms of their work commitments, making sure they're meeting those. And then trying to grow organically through new service offerings or new service mixes to really maximize revenue per visit. So, that's one of the places we focus. These companies tend to run pretty lean, so there's not as much opportunities in cost-cutting. So we try to focus on organic growth, top line revenue growth.

That's where we get the most bang for our buck. Of course, payer services and CIN participation is always a good first step to getting a lift.

Geoff Cockrell (03:04):

Clark, maybe a follow-up on that. When you guys are coming in, if it was a kind of a small provider-owned practice or maybe with a little bit of scale, but provider-owned, contrasting that with a smaller, already invested in platform, maybe it's a private equity fund, maybe it's an independent sponsor or family office, something like that. Are the problems that you described generally much more present in the provider owned businesses, or do you see those in sponsor owned as well?

Clark Bosslet (03:32):

I think they're probably different. So once you have private equity–backed platform, they usually immediately address a couple of things. Right? So again, we typically see really, really strong revenue cycle performance, revenue optimization. They usually take a good look at their payer contracts and make sure those are optimized. All of those sorts of things I think are part and parcel.

(03:50):

What we tend to not see is there's a bit of a laissez-faire of, "Hey, if it's not broken, we're not going to try to address it." So, there's a lot of hands-off approach initially to the practices post-acquisition, where we can typically come in and say, "Well, wait a minute, what's driving some of these costs? Why are you doing what you're doing?" Some of those questions.

(04:07):

I think the other big thing post acquisition is trying to create an incentive design where the physicians are able to maintain an ownership mindset. So I'm sure when I say that, I'm thinking driven towards margin. When they're left to their own devices, when there's truly private practice, they're obviously very, very focused on revenue optimization and driving down cost to maintain their margin because that becomes a direct payout for them. Once they're acquired, you can have, adopt an employee mentality where you're just kind of, "Hey, tell me when to show up, how long to work, and that's what you'll get out of me." And I think you really want to make sure you have incentive design so that they maintain that kind of ownership mindset.

Geoff Cockrell (04:49):

And Louis, of the available levers that you can pull in creating that alignment, there's different schools of thought on how to approach that. How effective do you see actual owned equity in providing that? Because obviously if you own something in a TopCo, the performance of an individual practice in order to the benefit of the overall enterprise and there's some alignment through that, contrasting that with ownership at some subsidiary level through let's say a sub MSO or similar type of models, how significant or insignificant do you find equity ownership in providing that alignment?

Louis Oster (05:26):

I think equity ownership is confusing for physicians. Even the, the deal structure itself is confusing for physicians and normalizing comp plus liquidity event potential is very confusing for physicians. And so I've found that phantom equity is a great mechanism to move people into a deal and get their participation. It's just a lot easier for them to understand and it ties out closer to their personally rendered services, the things they can see right in front of them. And so just the fact that they can understand it, because otherwise, trying to inform them on what a share is worth is not always an easy conversation because it's not their wheelhouse. They don't understand what it is. But if I can show them phantom equity with targets that they need to hit, you know, in order to earn that, it's a much clearer picture for them.

(06:08):

And I think there's some folks, probably a younger generation, that they're happy to have phantom equity. They don't feel like they need to be true owners in a practice, but that phantom equity is enough to persuade them to join and really can stay engaged in the business.

Geoff Cockrell (06:22):

Louis, I've drafted many kind of phantom equity constructs and there's different ways you can do it. You could draft phantom equity that is mirroring the economics of TopCo equity, which would entitle someone to liquidity event economics, but not usually entitling them to current period distributions. That's just typically, TopCo equity doesn't do current distributions.

(06:48):

You could also draft phantom equity as kind of mirroring the equivalent of a sub MSO, and that sub MSO construct oftentimes has current compensation components to it. When you say phantom equity and that as an effective tool, I'm assuming that you are meaning the equivalent of equity ownership at a level that's closer to where they work, but also is including some current distribution components.

Louis Oster (07:15):

That's exactly right. And so at the sub MSO level, it's more relatable to them or at the business unit level, it's more relatable to them. They can see it, they can feel it, so they're participating in it right from the get-go. The TopCo phantom equity is still oftentimes it's nebulous to them. And again, trying to help them have a line of sight into what their input is and what their output is or their outcome, it's a lot harder to educate them on that versus at the business unit or sub MSO level. I like to focus at the sub MSO level. It also gives me a chance to create alignment within that business unit to drive profits in that specific business unit versus thinking about a more nebulous TopCo.

Geoff Cockrell (07:53):

So Clark, moving from phantom equity at the MSO economic alignment constructs, to the basic comp model within the practice itself. For a number of years, investors and providers were enamored with the income repair model, it goes by EBPC models or some version where your compensation goes down in the context of the transaction to create the EBITDA that's being purchased. But the expectation is that over time, through a combination of maybe improving payer reimbursement rates, making investments to enable you to pull in ancillary service revenue streams, any number of those mechanisms would enable the doctor's compensation to increase over time. That hoped for and often half promised income repair has been more elusive to achieve. What do you think the current state of the market on that idea is?

Clark Bosslet (08:55):

I think you put it well. I think it's an idea that has seen the sun begin to set on it, because I just think that, to your point, you tend to see these providers post-transaction set at an artificially low compensation plan. And again, there's a lot of these true-ups and other kind of promises that are supposed to ultimately make them whole. What we see, echo what Louis said, a lot of that feels a little bit abstract. This idea of equity is very, very abstract. It's not something that they can check on the equity price on a day-to-day basis. And so even though that is out there, it isn't a salient incentive. And so instead, you have them held at an artificially low compensation level for this initial period. And then when that ends, there's usually a shock to the system, because they immediately want to float back up to a market level.

(09:41):

And like I mentioned in my introduction, I do a lot of work in hospital-based specialties, so anesthesia, radiology, neonatology, emergency medicine. And really in most of those, if not all, we've seen a lot of froth in the market. And so there's a lot of factors that are actually driving compensation up, and that kind of pent-up demand, you have to really plan ahead. You have to either plan ahead to absorb a market adjustment to get them up to the market level, or you have to find other kind of salient incentives or drivers to keep them aligned, to keep them in-house once they roll off of that initial term.

Geoff Cockrell (10:12):

I often think of that as the original sin of some of these models, in the sense that there was a period of time where the market just accepted as truth that you can safely scrape 30% of whatever the owner doctors were making pre-transaction, and that there would be income repair to boost that back up. That, the boosting, has proven difficult and the original assumption that you can just freely scrape that high of a percentage. I mean, there can also be many variables, like there could be ASC ownership and it can get much more complicated than what I'm saying, but the idea that you could scrape that much and the model hold together has been really tested. Louis, what's the current thinking on what is safe scrape zones, and has that changed?

Clark Bosslet (11:00):

Louis, is it fair to say that since the multiples are not what they used to be a few years ago, we are seeing less obsession over trying to drive that EBITDA up to the absolute maximum value. And so the reasoning behind that scrape has started to diminish a little bit, plus everything that Geoff said, that there's a realization that there's going to be this required adjustment downstream.

(11:23):

The last thing I'll say is that if you do that scrape, then post-transaction, it makes it much harder to bring in new physicians, new providers, because you've set this artificial rate. And so what you end up seeing is people hiring in who didn't necessarily get the transaction value, who are now coming in at the true market rate and there's a huge inequity within the practice, which can lead to issues as well.

Louis Oster (11:46):

Yeah, actually that was a great point, Clark. And that is the paradox of this, is you need that scrape to get the return, which is what the MSO and the portfolio company wants. But in situations where you have leaving doc deals, if the scrape is too great, the replacement physicians or the successor are just not interested because they have economic hurdles that they don't feel comfortable clearing. And when you have to go through financial projections with them, they find themselves very intimidated by trying to continue to recover those monies years down the road, at the same time, earn an opportunity for their own liquidity event. So, it's a paradox.

(12:18):

I see people lowering it in order to bring in new doctors, but I think it also depends on the market. So in rural markets where it's harder to recruit to, that's where you'll see they'll lessen the scrape there, but in markets where it's easier to recruit to, they'll continue with the scrape. And then it also depends on growth potential.

Geoff Cockrell (12:32):

I think that's right. And any model that sets up either two different classes of employed physicians is going to be problematic. And if you can't set up two different classes of physicians, then whatever class you're setting up has to be within the zone of market or you're just going to be walking into trouble for the foreseeable future.

(12:51):

Louis, so when the transaction is closed and the private equity fund is walking in, especially if you're buying from a group of provider owners, they would often have fewer control features over the business itself. So when you're coming in and layering in more professional management controls with a provider business, what do some of those things look like?

Louis Oster (13:16):

Geoff, I like the concept that I refer to as relentless incrementalism. And what I mean by that is building an operating model that gives leaders and operators a very clear line of sight at the business unit level into performance across a number of different functions. These practices, performance, ebbs and flows, that could be revenue, that could be expenses, some combination thereof, or different things like revenue cycle. And so, giving your operators a clear line of sight to quickly make changes, because success oftentimes is about making more and frequent changes than one major lever. And so we really want to build those controls into the system so that they can make regular, frequent, and impactful changes on a quick basis. That will ultimately drive success in a business where there's variability. And if you have a lack of variable demand, you really need those controls so you can look at where to expand and where to contract as well.

Geoff Cockrell (14:04):

I often see a tension experienced by platforms that are doing a lot of smaller add-on acquisitions. And that tension is when they're acquiring small practices, there's a desire by the sellers of those practices to maintain a lot of the features of their practice before the transaction. And that's at tension with centralized command and control. Clark, how would you speak to that tension and where do you think people should come out as an owner in those businesses on that tension?

Clark Bosslet (14:39):

I think that's a fairly classic tension. And I think a lot of times during the initial sales process, you hear a lot about how much relative autonomy is going to be retained by the local practices to make a lot of those key business decisions. And then naturally over time, I think you do see this kind of centralization and standardization, which again, if the local practices don't understand it, if they can't buy into it, if the benefits of that scale and that centralization are not made clear to them, I think there's going to be a lack of trust that can make things very challenging.

(15:11):

I think very quickly, these platforms need to decide, what do we truly want to centralize and standardize, and where do we want to continue to empower our local practices to maintain that degree of accountability? The reality is, no matter how large the platform is, there is a relationship between the local providers and the patients or the health systems that they're working with. And they have to feel empowered to manage those relationships.

(15:40):

In the groups that I've seen that do it the best, there's no sense that they're now part of this larger platform, right? That day-to-day customer service is as strong as ever. And I think that's part and parcel with being a really high functioning group. And they're really just, all of the benefit of the transition is all of the things that are happening behind the scenes that again, the customers, the

health systems, the patients are never actually seeing because they're probably on a better tech stack or a better informatics system and all those sorts of things behind the scenes, but nothing's really changing on the front lines.

Geoff Cockrell (16:13):

Louis, if I stipulate that having a group like you involved with the transitioning of those practices into more professional management right from the jump is the ideal scenario. How often are you encountering that ideal scenario versus being called in when things are in trouble? And how does it play differently for what you're doing if things are in trouble, and what levers do you have then?

Louis Oster (16:41):

I'm almost never called in before things are in trouble. It's always about when things are in trouble. And I think that's the challenge and that's one of the things I would implore some of these groups to think about is involving us right from the get-go and build out business plans and playbooks and controls and balanced scorecards and everything so that we can manage the business better.

(16:58):

But when we do come in, when things are in trouble, revenue cycle is usually one of the first areas we look at. One of the second areas we're going to look at is organic growth. I know there's a lot of groups that want to pursue de novo growth, and de novo growth is tough flooding. There's a big capital investment up front and you're going to new markets without any assurance that you're going to be able to recover that in a short period of time. So it's focused on revenue cycle, organic growth, and optimizing provider productivity. Those are the quickest ways to improve performance in short term.

Geoff Cockrell (17:27):

So Clark, in an ideal world, you would be part of the front end underwriting of a platform by a buyer. When you're doing that, what are you looking for and what kind of a plan are you putting in place so that if the buyer's able to execute on it, they've got built-in runway of growth? What does that front end underwriting and plan look like?

Clark Bosslet (17:50):

I think that we know the medical group world as well as anyone. So we can come in, we can look at, is the job being consistently defined? Like Louis said, are the incentives that are in place the right ones? We'll look at things like, how are they staffing the clinic? How are they utilizing the clinic? Wait a minute, why is no one ever working on a Friday? Those sorts of questions that tend to come up in these conversations. We'll obviously look at payer contracts. I would say that ECG's payer team is up there with anybody in the industry. So we can look at some of those things very quickly and

understand, what are the key kind of underlying assumptions that are driving this and what is the actual likelihood of achieving that to have a much better understanding of what the value capture's going to look like?

(18:32):

And then obviously, like Louis said, on the back end, we're often brought in to say, "Hey, wait a minute. We're X years out from our transaction and we're struggling with some of these areas." And, "Oh, okay, it is because we have vastly inconsistent CFTE definitions or job descriptions across." We have vastly different utilization of advanced practitioners to support staff in our clinics. There's just a lot of things that can feel like low-hanging fruit, but in the day-to-day, those things can get lost, and those are huge optimization opportunities.

Geoff Cockrell (19:01):

And Louis, last question will go to you. a lot of these kind of sectors are somewhat mature in the consolidation. There's less new platform creation in many of them, but at the same time, there's mixed thoughts on what the future looks like and how much kind of improvement is available. From where you sit and what you know and what you guys do when you come into these platforms, is your view of the world that there's a lot more growth in many of these sectors that folks have not yet achieved if they could just do better at some of these optimization pathways? Are you bullish on the idea of consolidation overall, or what has your experience in this work led you to think about the future?

Louis Oster (19:47):

I am bullish on consolidation, but I'm bullish on consolidation in so far as firms are willing to be a strategic, hold onto it, really invest in performance long term, which is oftentimes contrary to their ethos and where they began, which is, we want a short term, we want to roll this over in three to five years. So if you're willing to be a strategic, hold onto it, invest in it. You might have to recognize that with the cost of capital right now, you're not getting a 3X return on your cost of capital, it might be lower than that. If you're willing to do that, there's a lot of opportunity.

(20:13):

But it also, I think you have to find spaces where you can solve for provider supply and demand. If you can modify your care model, bring in more PAs, there's a lot of opportunity for growth. If you're just dependent on say the number of graduates in a specialty, a lot of those programs aren't growing and so you're a spot where you don't have revenue generators. The providers are always the only revenue generators. So I'm bullish, in so far as you're willing to invest in operational improvements.

Geoff Cockrell (20:38):

Louis and Clark, this is an area where I spend quite a bit of time and it's interesting to talk to you guys down in the weeds of many of the kind of mechanisms that I might be drafting. It's very interesting to hear your thoughts on where things can improve and the possibilities that are out there. But thanks a lot for joining the podcast, this has been a ton of fun.

Louis Oster (20:55):

Thank you for having us.

Clark Bosslet (20:56):

Thanks so much for having us.

Voice Over (21:02):

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.

(21:15):

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