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Private Equity Investment in Dermatology Practices: Adding More "Skin to the Game" Through a Cosmetic Service Line

Geoffrey C. Cockrell[1] and Erin E. Dine[2]

Bigger is not *always* better. However, one is likely to consider a bigger, more efficient, more resourceful, better managed medical practice that offers economies of scale and produces higher quality patient care as not only "better," but equipped to survive the ever-changing and uncertain United States healthcare industry.[3] In the age of an unreliable healthcare regulatory climate accompanied by confusing and restrictive federal and state laws and regulations, varying and perplexing reimbursement models, failing negotiations with necessary third-party payors, and the necessity to integrate expensive technological advancements, independent medical practices can struggle to stay current, relevant, and survive. Enter: private equity investors.[4]

Lately, the highly fragmented healthcare industry has become a haven for investors, specifically private equity funds as such investors seek to transform a surviving medical practice to a profitable and thriving one that can provide more efficient, effective, and high-quality health care through focus and consolidation efforts.[5] According to PwC Network, the surge of investments in the healthcare industry is not expected to slow down as more than $10 billion was invested in healthcare transactions in the first half of 2018[6] and "[p]rivate equity's purchases of healthcare divestitures are expected to continue in 2019 as the sector looks to invest the cash it has raised, a reported $624 billion ready for investment across industries as of July 2018."[7]

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[3] "According to a report by Accenture, the share of U.S doctors in independent practice has plummeted to 33 percent in 2016 from 57 percent in 2000." Harry Gamble, *Is Private Equity Helping or Hurting Healthcare?*, MOD. HEALTHCARE (July 10, 2018, 1:00 AM), https://www.modernhealthcare.com/article/20180710/NEWS/180719998/is-private-equity-helping-or-hurting-healthcare [hereinafter *Is Private Equity Helping*].

> The uncertainty over healthcare policy in Washington is probably driving the integrated healthcare delivery systems and large hospitals to bulk up almost as a counterweight to the uncertainty they face. They know that if you are bigger, you are in a better position to survive whatever may come your way.

Id.

[4] *But cf.*, *Is Private Equity Helping*, *supra* note 3 (noting how some people believe third-party investment in physician practices "fosters monopoly control while driving up prices"). Anthony LoSasso, professor of health policy and administration at the University of Illinois at Chicago's School of Public Health, is quoted saying:

> I think the jury is still out on whether those larger systems can translate that scale into quality improvements . . . . [w]hat I do know is they can translate that scale into price increases. That means insurers are going to have to pay more, which translates on the consumer side into higher premiums.

Id.

[5] *See* Vincent M. Kickirillo & Zachary Sadau, *Private Equity Deals in Dermatology*, VMG HEALTH (May 10, 2018), https://vmghealth.com/blog/private-equity-deals-dermatology/ ("The dermatology market is a highly fragmented market, with the three largest industry practices accounting for less than 2.0% of revenue as of 2016. In such a fragmented industry, private equity investors see an opportunity to create economies of scale through industry consolidation." (internal citations omitted)).

[6] Mary Anna Pazanowski, *Private Equity Investment in Health Care Stays Strong*, BLOOMBERG BNA (Sept. 21, 2018), https://www.bna.com/private-equity-investment-n73014482737/.

[7] *Private Equity: Healthcare's New Growth Accelerator*, PwC, https://www.pwc.com/us/en/industries/health-industries/top-health-industry-issues/pe-in-healthcare.html (last visited on Mar. 12, 2019).

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The profitability of dermatology practices across the country has increased due to aging populations, the extensive use of tanning beds, and increased awareness and detection of skin cancer together with the fact that skin cancer accounts for roughly $2.9 billion in Medicare charges annually.[8] Dermatology has been one of the "most active specialties within physician services in pursuing strategic transactions" and since 2011, dermatology has been a target for almost every healthcare-focused private equity group.[9] In terms of the actual number of medical practice acquisitions, "15% of recent practice acquisitions by private equity firms have been dermatology practices — even though dermatology represents only about 1%" of United States physicians.[10] Based on historical numbers and future expectations, it is clear that private equity capital has become a crucial player in the dermatology market over the last seven years and is here to stay.[11]

I. Riding the Waves of Consolidation: Diversification Through Cosmetic Services and Products

Investors experienced high returns during the "first wave" of consolidation that occurred after the passage of the Patient Protection and Affordable Care Act in 2010 of physician practice management ("PPM") models in dermatology, vision, and dental sub-specialties and are now contemplating what the second wave of PPM consolidation will look like.[12] After an initial investment in the dermatology market in a "platform" medical practice,[13] a private equity fund, its management company, and friendly physicians look to take a dermatology practice to the next level by significantly increasing a practice's cash flow with equity, experience and efficiencies.[14] "After an investment period of three to seven years, the private equity group and its physician partners aim to sell the

[8] Amber McGraw Walsh et al., *Investors' Interest in Dermatology Is More Than Skin-Deep*, Law360 (Aug. 14, 2015, 10:55 AM), https://www.thehealthcareinvestor.com/files/2015/08/Investors-Interest-In-Dermatology-Is-More-Than-Skin-Deep2.pdf; *Why Are Melanoma Rates Increasing?*, SkinVision (June 27, 2017), https://www.skinvision.com/articles/why-is-the-melanoma-skin-cancer-rate-increasing.

> By 2019, there will be 54 million Americans over the age of 65, up from 46 million-plus today, according to a report by the U.S. Department of Health and Human Services' Administration on Aging. Skin cancer, particularly melanoma, is on the rise too, striking about 3.5 million people annually, according to the American Cancer Society.

Patrick Krause, *Private Equity Firms Are Suddenly Buying Dermatology Practices – Here's Why*, Bus. Insider (Aug. 22, 2016, 2:54 PM), https://www.businessinsider.com/why-private-equity-firms-buy-dermatology-practices-2016-8.

[9] Robert Aprill et al., *Hot Physician Specialties for Private Equity Investment*, Becker's ASC Rev. (June 14, 2017), https://www.beckersasc.com/asc-transactions-and-valuation-issues/hot-physician-specialties-for-private-equity-investment-2.html.

[10] Bob Kronemyer, *6 Concerns About Practice Consolidation*, Dermatology Times (Jan. 11, 2018), https://www.dermatologytimes.com/dermatology/6-concerns-about-practice-consolidation; *see* Emma Court, *Medical Practices Have Become a Hot Investment – Are Profits Being Put Ahead of Patients?*, MarketWatch (June 19, 2018, 8:36 AM), https://www.marketwatch.com/story/doctors-are-being-bought-up-by-private-equity-and-its-your-health-on-the-line-2018-06-08.

[11] Clint Bundy, The Dermatology Market: A Tidal Wave of Private Equity Investment, Practical Dermatology 37, 37 (Sept. 2018), http://practicaldermatology.com/pdfs/PD0918_CF_MandAs_Part1_102518(fixed).pdf.

[12] Erin E. Dine & Holly Buckley, *The Next Wave of Consolidation in PPM Models: Oncology, Urology, Vascular & Neurology*, Health Care Investor, https://www.thehealthcareinvestor.com/2018/03/articles/healthcare-services-investing/the-next-wave-of-consolidation-in-ppm-models-oncology-urology-vascular-neurology/ (last visited Mar. 11, 2019).

> In the mid-1990s, many [management services organizations ("MSOs")] started investing in both independent physician practices and hospital-based physician groups; however, by 2002, 80 percent of the top ten public MSOs were in bankruptcy after failing to reach financial benchmarks. It was not until after the 2010 passage of the Patient Protection and Affordable Care Act [("ACA")] that MSOs regained popularity, in part due to the ACA's restructuring of payment and delivery models, such as bundled payments and [accountable care organizations]. Not only are MSOs becoming more common, but they are also becoming larger, and raising capital for buyouts.

Jessica J. Bailey-Wheaton & Todd A. Zigrang, *Management Services Agreements: Considerations for Fair Market Value*, 11 Health Cap. Topics (May 2018), https://www.healthcapital.com/hcc/newsletter/05_18/HTML/MSA/convert_valuing_msas_hc_topics_5.23.18_final.php.

[13] "Platform companies" are defined as

> companies acquired by private equity firms that serve as the primary vehicle for other acquisitions to be made in the sector. Platform companies typically have seasoned management teams in place that are accustomed to making acquisitions. With each acquisition, efficiencies are gained by eliminating redundant capabilities that are already available at the platform business.

Catherine J. Robbins et al., *Private Equity Investment in Health Care Services*, 27 Health Aff. 1389, 1398 n. 7 (Sept./Oct. 2008), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.27.5.1389.

[14] Alex L. Bateman & Douglas W. Lundy, *Should I Sell My Practice to Private Equity?*, Am. Acad. Orthopaedic Surgeons, https://aaos.org/AAOSNow/2018/Jun/Managing/managing02/?ssopc=1 (last visited Mar. 13, 2019).

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practice and receive back two to five times the amount of equity that it originally placed into a transaction."[15] Dermatology practices are now considering how they will land as the "second wave" of PPM consolidation commences and are looking to better position themselves in the market in contemplation of this wave. Investors are also contemplating their exit strategy and looking to better position dermatology practices that already experienced an initial wave of private equity investment so that investors can sell the practice during a "secondary buy-out." In the private equity cycle, one critical strategy that private equity investors deliberate is the timing of the "window of opportunity" so as to successfully exit an investment at the best possible purchase price, without being the last one standing.

Though the importance of scale cannot be overstated, investors are seeking practices that have certain qualities that can withstand unforeseen reimbursement trends, including a diversified reimbursement portfolio. Certain specialty medical practices, such as dermatology practices, could look to develop opportunities around cash-pay patients so as to achieve such coveted reimbursement diversification. One such opportunity is to develop or grow a practice's cosmetic service line, so as to diversify its payor mix and service lines.[16]

Cosmetic procedures, services, and products are largely provided on a self-pay or cash basis, generally avoiding the regulatory and payment frustrations associated with third-party government and commercial payors.[17] While general dermatology services and Mohs surgical procedures provide a dermatology practice with steady and recurring cash flow, a dermatology practice with a strong cosmetic service line can offer investors an opportunity to capitalize on upselling opportunities to increase its growth.[18] Cosmetic services attract consumers who are willing to pay cash for a luxurious medical spa experience, while maintaining the high-quality care expected and provided at a medical practice. Private equity funds have the capital and experience to profit from this lure.

It is undeniable that the offering of cosmetic services can offer a practice a great return; however, there are some regulatory considerations that a dermatology practice must consider in connection with the provision of medical spa or cosmetic services such as Botox, laser treatment for hair removal and skin resurfacing, chemical peels, HydraFacial treatment, microdermabrasion, and others. This Article navigates through some important, albeit often neglected, regulatory considerations associated with the offering of a cosmetic services line including structural considerations given varying state law corporate practice of medicine doctrines, compensation models, and facility licensure requirements.

II. Structural Considerations & State Law Corporate Practice of Medicine Doctrines

Although prohibitions vary from state to state, most states' laws provide that a non-licensed individual, which includes a business corporation owned by non-licensed individuals, cannot practice medicine or employ a licensed professional (e.g., a physician) to practice medicine. Therefore, private equity funds and other non-licensed individuals are generally prohibited under most states' laws from directly or indirectly owning entities that employ licensed professionals because of such state laws that prohibit the corporate practice of medicine and fee-splitting between licensed professionals and non-licensed individuals.

As such, in states that prohibit the corporate practice of medicine, private equity funds will typically implement a structure that is known as the "MSO-PC structure." In this model, the private equity fund will fund a management services organization ("MSO") and a physician associated with the MSO, also known as the "friendly physician,"[19] will separately form a professional corporation ("PC"). The MSO and PC will enter into an administrative services agreement or a management services agreement, which will set forth the specific administrative services and business functions that the MSO will provide to the

[15] Bundy, *supra* note 11, at 37.

[16] "The desirability of individual practices for acquisition by equity-backed groups is often determined by whether or not a practice . . . [o]ffers a mix of medical and cosmetic dermatology." Emily Margosian, *Pulling Back the Curtain on Private Equity*, 28 Dermatology World 32, 40 (Jan. 2018).

[17] *Cosmetic vs. Medical Dermatology: A Widening Gap?*, Dermatologist (Sept. 4, 2008), https://www.the-dermatologist.com/article/1804.

[18] Kickirillo & Sadau, *supra* note 5 ("While receiving steady cash flows from the general and Mohs surgery side, a private equity firm with additional marketing experience might be able to further extrapolate revenues and value from the practice through the cosmetic side.").

[19] Investors typically prefer to have more than one friendly physician form such professional corporation.

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PC pursuant to the agreement in exchange for an administrative services fee, while retaining all medical decision making with the physicians and other licensed medical professionals.[20]

Private equity companies investing in dermatology practices often set up the MSO-PC structure in connection with a dermatology practice's provision of dermatology services and Mohs surgical procedures. However, dermatology practices frequently have a separate legal entity in connection with the provision of cosmetic services. Although the definition of the "practice of medicine" varies from state to state, some states incorporate certain cosmetic services into the definition of the "practice of medicine." Therefore, implementing a corporate structure of a dermatology practice's cosmetic services entity that complies with a state's corporate practice of medicine doctrine is also important.

For example, in Michigan, the Michigan Department of Licensing and Regulatory Affairs ("LARA") considers the use of lasers to be the "practice of medicine"[21] and LARA expressly provides that "corporations and limited liability companies using lasers for medical or dental services may only incorporate or organize as professional service corporations . . . or as professional service limited liability companies."[22] Similarly, the West Virginia Medical Board issued a public policy statement on lasers, which stated that the West Virginia Medical Board considers the use of lasers, specifically ionizing radiation, pulsed light or radiofrequency devices as the "practice of medicine and surgery" under the provisions of West Virginia Code.[23]

Consequently, certain states, including Michigan and West Virginia, require an entity that provides certain cosmetic services, such as laser services, to be formed as a PC or a professional limited liability company, which in most states requires complete ownership by licensed physicians or other licensed professionals, depending on the circumstances. Therefore, a management company owned by non-licensed professionals could not directly own in a legal entity that provides the cosmetic services that constitute the practice of medicine. When structuring a dermatology practice, most practices neglect to consider the intersection between a specific state's corporate practice of medicine doctrine, the definition of the "practice of medicine," and the scope of services offered by such practice, including the scope of offered cosmetic services; however, a private-equity backed practice must pay specific attention to the structural framework to ensure compliance.

Deciding and analyzing the post-closing structure of a dermatology practice after private equity investment is a technical exercise that varies substantially from state to state. A practice must carefully decide on its structure and such structural determinations will depend largely on nuances contained in state law and on the subject arrangement.

III. "Skin in the Game" Compensation and Equity Models for Anchor Dermatologists

When investors are looking for potential partners in the dermatology space, investors are placing a high

[20] For example, in California, the Medical Board of California explains that the following "business" and "management" decisions and activities result "in control over the physician's practice of medicine" and

> should be made by a licensed California physician and not by an unlicensed person or entity" (i.e., a management company): (1) Ownership is an indicator of control of a patient's medical records, including determining the contents thereof, and should be retained by a California-licensed physician; (2) selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants; (3) [s]etting the parameters under which the physician will enter into contractual relationships with third-party payers; (4) [d]ecisions regarding coding and billing procedures for patient care services; [and] [a]pproving of the selection of medical equipment and medical supplies for the medical practice.

Corporate Practice of Medicine, Med. Board Cal., http://www.mbc.ca.gov/Licensees/Corporate_Practice.aspx (last visited Mar. 13, 2019).

[21] *See Use of Laser Equipment by Health Professionals*, Dep't Licensing & Reg. Aff., http://www.michigan.gov/lara/0,4601,7-154-61343_35413_35426-182821–,00.html (last visited Mar. 13, 2019) [hereinafter *Use of Laser*]. Specifically,

> [l]aser use falls within the definition of the practice of medicine in the Public Health Code because they are used for the 'diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition by attendance, advice, device, diagnostic test, or other means.

Use of Laser Equipment by Health Professionals: Position Statement of the Michigan Department of Licensing and Regulatory Affairs (Dec. 5, 2005), https://www.michigan.gov/documents/lara/lara_laser_equipment_position_statement_477918_7.pdf.

[22] *See Use of Laser*, *supra* note 21.

[23] American College of Surgeons, Public Policy Statement on Surgery Using Laser, Pulsed Light, Radiofrequency Devices, or Other Techniques, 1, 1 (July 9, 2007), https://wvbom.wv.gov/Position_Statementsnew.asp (noting that such policy statement was adopted by the West Virginia Medical Board on February 9, 2007); *Tattoos and Body Piercing*, 14 W. Va. Board Med. Q. Newsl. 1, 6 (Oct. 2010-Dec. 2010).

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value on a practice's reputation, brand and its anchor physicians. That being said, by placing such a high value on these factors, investors are expecting that the anchor dermatologists of a target practice will remain part of the practice for multiple years after the applicable acquisition's closing date. Therefore, investors are now looking to incentivize dermatologists to be partners through unique and innovative compensation and integration models within the MSO-PC business model.

One way to increase the longevity of investment of a dermatologist and to ensure a dermatologist has "skin in the game" even after the sale is to construct the employed dermatologist's compensation based on a certain percentage of the collections personally performed and provided by such dermatologist. This model can also be implemented in connection with cosmetic services.

Cosmetic services are typically paid for on a cash-pay basis; therefore, cosmetic services do not typically involve third-party reimbursement from Medicare, Medicaid, or commercial payors. Consequently, physician compensation in connection with cosmetic services typically does not implicate federal fraud and abuse laws like the Physician Self-Referral law (commonly referred to as the "Stark Law") or the Federal Anti-Kickback Statute; however, to the extent a practice receives reimbursement from commercial payors for cosmetic services, practices need to consider state law fraud and abuse statutes that include all-payor kickback statutes.[24] Further, even if federal healthcare reimbursement is not involved, certain financial relationships, such as compensation models based on a percentage of cosmetic sales, may still nonetheless implicate similar state prohibitions that apply regardless of payment source.[25]

An alternative way to increase a physician's skin in the game, or in the platform, after an acquisition is to not only implement a percentage-based compensation model, but also to form a regional MSO-PC model whereby physicians can invest rollover equity in a regional MSO that is geographically concentrated. Establishing a regional MSO-PC model could also lend itself to a periodic distribution model to shareholders, so as to repair some of the income lost as a result of the acquisition.

Another innovative compensation model that practices can establish and implement after private equity investment to ensure alignment and longevity with physicians is an earnings before physician compensation pool (the "EBPC Pool") from which certain employed physicians can be compensated in accordance with earnings encapsulated within the EBPC Pool. There is a significant amount of flexibility in establishing this alignment strategy, but most groups typically set the EBPC Pool to equate to 60–80 percent of the net practice earnings, after deducting certain expenses and losses, before physician compensation, excluding net practice earnings from pathology and other ancillary services and designated health services.[26] The EBPC Pool is also only effective in achieving alignment and longevity amongst anchor and brand physicians when there is an internal hierarchy amongst the physicians splitting the EBPC Pool, which could depend largely on the applicable physician's experience and leadership. Ultimately, by establishing the EBPC Pool, stakeholder physicians are incentivized to grow the pool through add-on acquisitions and physician recruitment efforts.

Although implementing an EBPC Pool may reduce the total purchase price amount in connection with the initial transaction, the EBPC Pool offers attractive qualities to physicians including faster income repair, physician autonomy, and incentives to make the EBPC Pool larger. This model, however, is still somewhat in its infancy and is also heavily dependent on state law and the specific nuances contained in federal fraud and abuse statutes. Therefore, intense scrutiny and care are necessary when structuring physician compensation models using an EBPC Pool.

IV. Facility Licensure

Professionals who render medical services are required to obtain individual medical licenses, but

[24] *See, e.g.*, Kathryn Leaman, *State Anti-Kickback Statutes: Where the Action Is*, Health L. & Pol'y 22, 22 (Fall 2008), https://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1082&context=hlp.

[25] Alexis Reynolds et al., *A Beautiful Investment: Regulatory Considerations for Investors in Cosmetic Dermatology*, 2017-9 Bender's Health Care Law Monthly 01 (2017) ("It is . . . important to note that simply excluding government reimbursable goods or services does not necessarily sanitize an otherwise impermissible arrangement.").

[26] The practice entity would use the other 20–40 percent of the earnings before physician compensation to pay for administrative services, including the administrative services fee. *See supra* note 20.

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there are some states that require specific facility licenses in connection with the provision of medical spa and cosmetic services and products. For example, in Michigan, LARA issues cosmetology establishment licenses to cosmetology establishments[27] that offer "skin care services."[28] Michigan law broadly defines "skin care services" to include:

1. Beautifying the skin of the body of an individual by the use of cosmetic preparations, antiseptics, tonics, lotions, or creams, including body wrapping.

2. Cleansing or stimulating the skin of the body by the use of the hands, devices, apparatus, or appliances, with or without the use of cosmetic preparations, antiseptics, tonics, lotions, or creams.

3. The temporary removal of hair from the body of an individual by the use of depilatories, waxes, razors, scissors, clippers, or tweezers.

4. Giving facials, applying removable makeup, applying eyelashes, or any other application of a preparation or beauty enhancement to the body of an individual but does not include applying permanent makeup or the use of tanning equipment.[29]

In Michigan, a cosmetology establishment must obtain a cosmetology establishment license, and Michigan law does not currently include any exemptions for physician group practices. Therefore, if a dermatology practice in Michigan offers laser hair removal, facials, chemical peels, microdermabrasion, or any other "skin care services," such practice must obtain a cosmetology establishment license, issued by LARA.

Similar to Michigan law, other states may require medical spas or facilities that provide cosmetic services to obtain a separate facility license. Therefore, prior to expanding a practice's service lines to include cosmetic services, a practice should research and analyze applicable state law to see if a separate facility license is required, so as to avoid penalties and to ensure compliance with state law.

V. Conclusion

Big changes, larger practices, and greater investments are on the horizon for the dermatology subsector, which most consider a positive. Betsy J. Wernli, MD of Forefront Dermatology was quoted saying:

> From a physician's perspective, it's just harder and harder to make a go of it alone . . . . [t]here are the increased constraints that the government has put on us — increased regulations on how to chart and code and bill — that have just made practicing medicine as a doctor much harder. To be quite honest, all the extra requirements in addition to providing quality care become so overwhelming that it's really hard for a single practitioner to do it alone.[30]

Contracting with a private-equity backed management company can allow a medical practice to focus on medicine, rather than managing every business and administrative function of a medical practice.[31] In addition, with increased scale developed by private equity investment, a dermatology practice can also gain stronger negotiating power with payors.[32] Investors can add significant value to a dermatology practice by providing a practice what it needs in order to support internalizing specialty practices, such as laboratory and cosmetic services. Investors can also assist dermatology practices specifically by growing its cosmetic service line so that it is not only attractive to consumer-patients willing to pay cash for services, but also investors in the second wave of healthcare PPM consolidation looking for a diversified reimbursement mix to sustain uncertainty and changes in the future healthcare landscape. However, investors are looking for practices with a cosmetic service line that is not only successful economically to its bottom line, but also compliant with law.

[27] "Cosmetology establishment" is defined under Michigan law to mean "the premises on which cosmetology or 1 or more of its services are rendered or are offered to be rendered. Cosmetology establishment does not include a school of cosmetology." Mich. Comp. Laws § 339.1201(e) (1980). "Cosmetology" is defined to include the following services: (1) hair care services; (2) skin care services; (3) manicuring services; and (4) electrology. *Id.* at § 339.1201(d).

[28] *Id.* at § 339.1201.

[29] *Id.* at § 339.1201(q).

[30] Margosian, *supra* note 16, at 33.

[31] Kickirillo & Sadau, *supra* note 5 ("Through consolidation, private equity firms are able to leverage back office functions such as marketing, billing, supply inventory, compliance, and other administrative activities across multiple locations.").

[32] *Id.*