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# How Distressed Dental Service Organizations Can Manage Through the Post-COVID Environment

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Between 2015 and 2020, private equity firms made more than 50 platform investments in dental service organizations (DSOs). The vertical was attractive to private equity investors as the sector was large (over $130 billion in annual spend) and highly fragmented (only 10% of dentists were affiliated with a DSO in 2019 according to the ADA) with most individual practices well positioned to significantly benefit from cross-selling of specialty services such as periodontics, orthodontics, and other cosmetic services. In fact, PE firms began aggressively "rolling up" dental practices around a regional "anchor" dental practice with many of these large dental platforms then trading between PE firms at multiples exceeding 10x EBITDA, with leverage in the transactions exceeding 5x to 6x EBITDA. In this environment, private equity firms began to replace other practicing dentists as the primary source of liquidity for dentists seeking to retire or relocate, despite the fact that private equity firms often had minimal sector experience.

Unfortunately, in their rush to invest in dental practices, private equity firms began to repeat many of the mistakes that investors made with physician practice management companies (PPMs) in the late 1990s. For a brief history lesson, in 1998 there were more than 30 publicly traded PPMs with an aggregate market capitalization more than $11 billion. However, by 2002, 8 of the 10 largest publicly traded PPMs had declared bankruptcy, and many more were dissolved.

Starting in 2019 (despite the robust economy at the time), the same factors that caused public PPMs to fail in the early 2000s began to cause many challenges to private equity-backed DSOs, resulting numerous loan covenant defaults and liquidity shortfalls.

**The key challenges experienced by DSOs included:**

*Misalignment of incentives in practice management structure.* A dentist's primary motivation in entering a DSO arrangement is often to monetize their practice. Typically, the most senior and established dentist (around whose name the practice was built) receives the largest payouts in a buyout. However, once the transaction closes these providers have less incentive to continue working long hours to drive their compensation, while the increase in leverage and DSO management fees results in less cash flow to drive the growth of the organization. This misalignment in incentives offered by private equity firms often results in declining productivity and poor morale at the practice level that can impact the entire organization.

*Inadequate transition planning and underestimating provider turnover.* Another common challenge experienced by DSOs in acquiring independent practices has been the inability to maintain provider continuity and practice productivity after an acquisition. As discussed above, often in a practice acquisition, the established dentist will reduce hours or retire altogether after the transaction, and it has been a consistent challenge of a DSO to replace these providers in a timely manner. In addition, DSOs often underestimate the level of staff and patient loyalty to these founding dentists and the acquired practices often experience a second level of hygienist turnover, further reducing available "chair hours." Further, these acquired practices can then experience a loss of 25% or more of

patient volume within 6 months of acquisition, thereby greatly reducing the profitability of practice or even resulting in losses. Often it can take several quarters or even years to rebuild the patient volume after the provider base has stabilized.

*Over estimating overhead savings from consolidation.* DSOs often acquire dental practices using valuations that assume improved cashflow from significant reductions in practice overhead costs from centralizing scheduling, billing, and collections. DSOs then proceed to eliminate administrative staff at the practice level and shift patient support to centralized business centers, which has often proven to be an ineffective strategy, resulting in reduced practice productivity, lower collections, and patient attrition. The elimination of patient support staff frustrates the providers who rely on this staff to juggle schedules daily to maximize efficiency. It is the local practice support staff that can most effectively work with providers on a real-time basis to accommodate patient requests for appointment modifications and fill cancellations. When patient requests are directed to centralized call centers, the customer representative typically does not have the capacity to talk with the dentists and hygienists to accommodate changes (i.e. "squeeze a patient in") and must therefore reschedule to extended dates in the future, which results in deferred or lost appointments. Additionally, the local staff have the relationship with the patient and are best positioned to collect copays and deductibles and follow up on delinquent payments. Thus, while there are often opportunities to improve practice efficiencies in an acquisition, many DSOs actually impair DSO profitability by centralizing functions and eliminating practice staff to generate immediate cost savings.

*Failure to invest in practice integration.* In contrast to the mistakes described above, the most successful DSOs often add overhead in the form of regional personnel to provide hands-on support to individual practices in their adoption of standardized operating practices and compliance procedures, migration to more robust patient accounting and Customer Relationship Management (CRM (Customer Relationship Management)) software and transitioning to preferred vendor relationships. The regional staff and additional investment in training at the practice level will increase operating costs in the short run but results in more efficient and scalable practices in the long run. Those DSOs that fail to invest in the personnel and infrastructure to scale their practice generally fail to reap the benefits of consolidation and remain overly dependent on key "rain-maker" dentists to drive volume and revenue growth.

*Too much leverage, not enough capital.* Many private equity-backed DSOs have leverage exceeding 5x to 6x EBITDA. This level of leverage limits capital available to invest in new technologies, properly integrate new practices, or recruit and retain new providers that are necessary to keep the practices competitive. In addition, such levels of leverage offer no margin for error in addressing reimbursement declines, unexpected provider turnover, or other operational challenges.

Many DSOs were already facing significant challenges from these factors before the COVID-19 pandemic. During 2020, the pandemic caused widespread closure of offices and a general drop in demand for many dental services. This caused even the most successful DSOs to experience significant liquidity challenges and required most DSOs to seek additional funding from their lenders and investors to survive. Now, as the economy fully reopens, many of these DSOs are likely to require a second round of funding to become fully stabilized and profitable. According to a March 2021 survey by the ADA, 99% of U.S. dental practices are back open with patient volumes reaching approximately 80% of pre-pandemic levels. Given the high levels of leverage and the pre-pandemic operating deterioration of many DSOs, these upcoming funding decisions are likely to be difficult as both PE firms and lenders evaluate if they are better off continuing to invest in the DSO platform or seeking to liquidate the individual practices.

**Moving Forward: A Decision Framework**

The following key issues need to be addressed by private equity firms, lenders, and practice owners in deciding how to proceed with distressed DSOs:

1. Evaluate the market potential of the existing patient base. It is important to begin with an understanding of the DSO's existing patient population. How many of the patients in the database have been treated in the past year? Many patients held off going to the dentist over the past year and are just now considering scheduling appointments. Reduced office capacity also made appointments less convenient. How many lost visits can be recaptured with proactive calling initiatives and extending office hours? On the other hand, practices that were suffering patient attrition prior to the pandemic due to provider turnover, poor office management, or competitive challenges may find it even more challenging to reestablish a profitable patient base. In addition, demographic shifts that are emerging from the pandemic may have further implications. In any case, it is important to begin with an office-by-office analysis of patient trends, overlaying current sub-market demographics and competitor analysis to realistically assess the ability to establish a profitable patient base. Based on this assessment, the DSO can then develop a plan to rationalize the practice footprint to maximize resources for those locations and markets that are likely to experience the fastest recovery.

2. Recognize near-term opportunities to enhance profitability. For many DSOs, the current environment offers an excellent opportunity to consolidate offices or restructure leases to better position the platform for long-term profitability. In addition, medical supply and information technology vendors are likely to be willing to offer exclusive discounts to those willing to start buying again.

3. Stabilize the provider base. Once the DSO has developed a rationalized footprint, it is critical to make sure these locations are adequately staffed with permanent dentists. This stability is important for being able to attract both patients and staff. If locations are consistently challenging to staff and remain subject to high turnover, the DSO should consider shuttering those locations.

4. Deleverage. Ultimately these factors need to be evaluated to determine if a practice can realistically be stabilized in the short term and achieve sustained profitability. Many DSOs will likely require significant reductions in leverage. While there are a range of structures that can be considered for deleveraging, they consist of i) additional equity investment, ii) a consensual debt-for-equity conversion, or iii) a sale or recapitalization where the existing capital structure is replaced, often through a foreclosure or bankruptcy, depending on the magnitude of liabilities and cooperation of capital constituents.

**Conclusion**

For those DSOs that were experiencing structural challenges before the pandemic, the most cost-effective solution monetization, either through selling individual practice assets to another DSO or possibly back to its individual providers. However, for those practices with a stable provider base in which long-term demand for services is expected to return to historical levels, recovery is likely maximized by investing and stabilizing until demand recovers.

***Author Bio***

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