Managing Distressed Physician, Dental Groups in the Post-COVID Environment

By Gregory F. Hagood & Neil Luria, Senior Managing Directors, SOLIC Capital Advisors

Between 2015 and 2020, private equity firms made more than 75 platform investments in physician practice management companies (PPMs) and more than 50 platform investments in dental service organizations (DSOs). This investment frenzy was driven by private equity's desire to deploy its $1.5 trillion of dry powder in what was perceived as relatively safe growth verticals. Both the PPM and DSO sectors were seen as well positioned to benefit from aging demographics, with significant opportunities to consolidate highly fragmented markets.

In fact, large physician and dental practices were often acquired at multiples exceeding 10x EBITDA, with leverage in the transactions exceeding 5x to 6x EBITDA. In this environment, private equity firms began to replace health systems and managed care companies as the primary acquirors of provider practices, despite the fact that private equity firms often had minimal sector experience and offered no strategic synergies or valuation creation beyond limited operating efficiencies.

In their rush to invest in provider practices, private equity firms began to repeat many of the mistakes that investors made with public company PPM roll-ups in the late 1990s. For a brief history lesson, in 1998 there were more than 30 publicly traded PPMs with an aggregate market capitalization in excess of $11 billion. However, by 2002, eight of the 10 largest publicly traded PPMs had declared bankruptcy, and many more were ultimately 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 PPMs and DSOs. These challenges included:

1. **Misalignment of incentives in practice management structure.** Providers' primary motivation in entering into a PPM/DSO arrangement is often to monetize their practice. Typically, the most established and productive providers receive the largest payouts in a PPM/DSO buyout. Once the transaction closes, these providers have less incentive to continue working long hours to drive their compensation, while the increase in leverage and PPM/DSO management fees results in less cash flow available to pay the younger providers necessary to drive the growth of the organization. This misalignment in incentives often results in declining productivity and poor morale across the organization, which leads to provider

turnover and further impairs profitability.

2. **Failure to plan for declining reimbursement.** Similar to the late 1990s, when managed care began to replace traditional fee-for-service reimbursement, provider practices today face significant reimbursement challenges from the push by managed care companies to value-based reimbursement and the accelerating shift of the patient population from commercial insurance to Medicare/Medicaid plans.

   Most PPM/DSO practice valuations and capital structures did not account for the impact of significant reimbursement rate declines and generally assumed that consolidation would provide additional negotiating leverage to mitigate any rate declines. However, with few exceptions, PPMs and DSOs have rarely been able to achieve the critical mass necessary, given overall market-based reimbursement declines. Further, most private equity-backed PPMs do not have the critical mass or infrastructure investment to effectively bear risk, so they are unable to meaningfully benefit from the opportunities associated with value-based reimbursement.

   As a result, many historically successful practices are facing declining profitability simply due to a declining rate environment. This is particularly true in higher reimbursement specialties, such as orthopedics, cardiology, and gastroenterology, areas that have experienced a significant growth in interest from private equity firms. Further, the increased unemployment and resulting loss of commercial insurance during the COVID-19 pandemic will certainly accelerate these reimbursement challenges.

3. **Failure to create strategic value.** Many private equity-backed PPMs and DSOs fail to create unique value for the provider platform as a whole. They are simply an aggregation of practices with the hope that scale will result in operational efficiencies. In numerous cases, practices were acquired but never operationally integrated in the PPM/DSO.

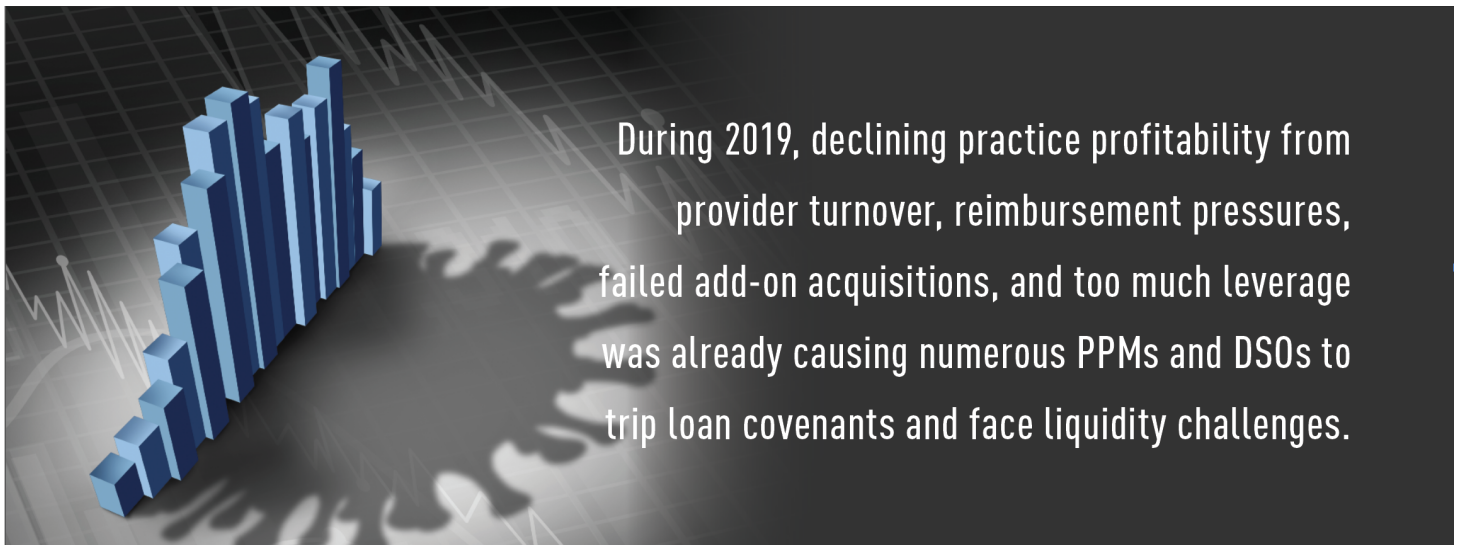
   In addition, PPM management fees and interest payments often negate any operational cost savings, while attempts at standardizing corporate overhead just make the practices more bureaucratic and less responsive to patients and providers. This is compared to the potential strategic benefits of a managed care acquiror (manage loss ratios, standardize quality) or health system (market share, enhanced reimbursement).

4. **Too much leverage.** Many private equity-backed PPMs and 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 PPMs and DSOs were already facing significant challenges from these factors before the COVID-19 pandemic. During 2019, declining practice profitability from provider turnover, reimbursement pressures, failed add-on acquisitions, and too much leverage was already causing numerous PPMs and DSOs to trip loan covenants and face liquidity challenges.

Post-COVID, the widespread closure of offices and general drop in demand for many services during the second quarter of 2020 have caused even the most successful PPMs and DSOs to prioritize and address significant liquidity challenges. Many PPMs and DSOs will require an incremental investment of two to three months of net working capital to become fully stabilized and profitable, assuming patient demand returns to normalized levels in the second half of 2020.

As a result, both private equity firms and lenders are at a critical juncture with respect to their PPM and DSO investments. Private equity firms must decide whether to commit the additional investment to "restart" these practices or to abandon their investments. If private equity firms decide to cease funding their PPM/DSO portfolio companies, lenders will need to quickly evaluate whether they are prepared to fund these practices to seek an enhanced recovery in the future or should attempt to monetize the practices today at distressed valuations.



A Decision Framework

The following key issues should be addressed by both private equity firms and lenders in deciding how to proceed:

Determine the commitment of the provider base. Before the pandemic, was the provider base either stable and productive, or was it experiencing significant turnover? Understanding the motivations and likelihood that the core group of providers are committed to the platform is fundamental to deciding whether to continue with the investment. Changing compensation structures at this point is difficult given the uncertainty of future volumes and unanticipated impact on provider behavior.

Evaluate the demand outlook for core services over the next six to 12 months. Many practices in the areas of primary care, dental, and dermatology that have high levels of basic recurring services provided by extenders have anecdotally reported seeing volumes return to relatively normal levels over the past month. However, many specialty services, such as orthopedics and gastroenterology, have not yet seen a pickup in volumes. Given the continued concern over a second COVID-19 wave and on-again, off-again restrictions on elective procedures, many do not expect these practices to return to normal levels until at least 2021.

In addition, there may be a permanent shift in practice protocols and patient behavior that emerges from the pandemic and impacts practice volume. This is particularly true for such practices as emergency room physicians. ER volumes (excluding COVID patients) have fallen severely during the pandemic, and there are concerns that changes around consumer adoption of telemedicine may permanently shift some of the volume out of ER practices to primary care practices or other venues. ER visits and office visits have always been among the most profitable services, so any shift in demand in these areas will likely cause a permanent impact to profitability.

Identify likely shifts in reimbursement. With significant unemployment likely to impact the economy for the rest of the year, the commercial payor mix is likely to decline across all sectors in the second half of 2020, with much heavier reliance on Medicare and Affordable Care Act (ACA) programs. How much and when the commercial payor mix improves will be critical to evaluating the long-term profitability of a practice.

Recognize near-term opportunities to enhance profitability. For many PPMs and 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 special discounts to those willing to start buying again.

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. Once it is determined that the practice can be stabilized, private equity investors and lenders will need to right-size the capital structure to provide the business with the greatest opportunities for success.

Many practices will likely require significant reductions in leverage. There are a range of structures that can be considered for deleveraging, including a consensual debt-for-equity conversion, foreclosure sale, or bankruptcy, depending on the magnitude of liabilities and cooperation of capital constituents.

A realistic evaluation of the outlook for each practice will be required for both private equity firms and lenders to maximize the recovery from their PPM and DSO investments.

A realistic evaluation of the outlook for each practice will be required for both private equity firms and lenders to maximize the recovery from their PPM and DSO investments. Most PPMs and DSOs will require significant additional capital over the remainder of 2020, so a disciplined approach to this evaluation is critical.

Conclusion

For those practices that were experiencing structural challenges before the pandemic, the most cost-effective solution may be monetization, either through selling the assets to another PPM/DSO or health system 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.

Topics:

HEALTHCARE (/ARTICLE-TAGS/HEALTHCARE)

COVID-19 (/ARTICLE-TAGS/COVID-19)

About The Authors

Neil Luria is a senior managing director of SOLIC Capital Advisors and leads the Restructuring and Distressed Asset Support Services divisions. He has significant experience negotiating and structuring acquisitions, divestitures, and structured settlements; overseeing asset liquidations; and restructuring leases. Luria has overseen operating and capital restructurings as CRO and has been involved in restructurings and sales of numerous physician and dental practices and healthcare services companies. He holds a law degree from the Boston University School of Law and a bachelor's degree from the Wharton School of the University of Pennsylvania.

Gregory F. Hagood, CFA, is a senior managing director of SOLIC Capital Advisors, where he oversees the Investment Banking practice, including merger and acquisition advisory services as well as private placements of debt and equity. He has extensive transaction experience across multiple areas of the healthcare services industry, including provider practice management, hospitals and health systems, long-term care, and home health. Hagood is a Chartered Financial Analyst (CFA) and a CIRA and holds the Certification in Distressed Business Valuation.