THE ART OF PRIVATE EQUITY

The latest trends and experiences from this growing area were shared during the 2019 Caribbean Eye meeting.

BY Y. RALPH CHU, MD; ERIC D. DONNENFELD, MD; CATHLEEN M. MCCABE, MD; STEPHEN V. SCOPER, MD; ALLISON W. SHUREN, JD; ROBERT J. WEINSTOCK, MD; AND WILLIAM F. WILEY, MD

Private equity firms have targeted ophthalmology practices in recent years due to the attractive investment opportunities the specialty offers with practice growth, an aging patient population, cash-pay services, and diversified service offerings.

During the annual Caribbean Eye Meeting in Cancun, Mexico, earlier this year, a panel of experts discussed the current state of private equity in ophthalmology and the potential advantages and pitfalls of this trend toward shared risk and ownership.

Robert J. Weinstock, MD: Everyone is looking at private equity from his or her own perspective, and there is a lot of information to share. In this roundtable discussion, we have ophthalmologists who are considering inviting investment from private equity and some who have already been acquired or partnered with. We also have Allison W. Shuren, JD, who can comment on private equity from a legal perspective.

My colleagues Eric D. Donnenfeld, MD; Cathleen M. McCabe, MD; and Stephen V. Scoper, MD, recently had their practices acquired by different private equity firms.

INITIAL EXPERIENCES

Cathleen, M. McCabe, MD: It has been a great experience for us. Ours was the first ophthalmology practice acquired by our group, so this past year there was a concentration on acquiring new practices and creating the infrastructure of the organization. That has been a bit of an adventure. We have been happy with the process. The acquisition has not changed anything that I do as far as taking care of patients, so it has been a good experience.

Eric D. Donnenfeld, MD: I agree. It is a misconception that private equity firms come in and control you and tell you what to do. These companies are made up of smart businesspeople who are spending millions of dollars to buy practices because they value what you do.

Our daily practice hasn't really been affected, although I realize that if we don't achieve our projected goals it could be a different story. Our goal is to keep growing and keep doing what we're doing. For me, the decision to partner with private equity was clear. I want to build great things. I looked at where ophthalmology is today and I saw that, if you want to do that, you need to have consolidation. For me, this was the opportunity to do what I love, and that is private practice ophthalmology, providing quality care to patients, and not having it dictated to me how I practice.

Stephen V. Scoper, MD: My advice is to start the education process as soon as you can, even if you are not currently interested. Two years ago, I knew nothing about private equity. Now, I know a lot. This is a long process. It's like taking a course in medical school. You start understanding how it works, and then you can talk on the same level with people who are not doctors. When you get to that level, you can start making educated decisions. At our practice, we looked at 15 or 20 groups, narrowed it down to four or five, and settled on one.

IMPORTANT CONSIDERATIONS

William F. Wiley, MD: If you decided to pass on this partnership, and some other practices in your area joined instead, how would that change the landscape of your market? As far as physician talent acquisition, I believe I could recruit younger doctors to my practice more easily if I wasn't doing a deal. In regard to administrative talent, I get a sense that private equity firms might be paying more or doing something differently to recruit, which may give them an advantage. How does the provider or staff talent pool change in a market after everything goes private?

Y. Ralph Chu, MD: I have the same perspective as you. I am still a sole practitioner in Minneapolis, where we have had two huge acquisitions recently. Our practice is doing well since that has happened, and we have seen a lot of applications from employees looking to shift their positions.

When I educated myself about private equity, I learned that the time horizon is important to consider. I think there is still an opportunity to be in private practice. I see a lot of young doctors opening their own private practice, being cash-only, and being successful, but this takes a special mentality.

Dr. Weinstock: Does that mean that private equity is off the table for you? Or do you still listen to firms that call you?

Dr. Chu: To be a good businessperson, you always have to listen. I don't think these firms will leave our sector any time soon. Their motivation is to return investment to their investors in 5 to 10 years. A lot of practices are on a 20- or 30-year horizon, and that makes me make different decisions. However, I still think there is opportunity out there.

Dr. Donnenfeld: Private equity is clearly not for everyone. I won't even think about arguing that. It's 10% of the market now, and in another year and a half it will be 25%. There will probably be another 25% of physicians working for hospitals. There is a general sense of consolidation now.

We have 80 doctors in my practice, including 11 partners. Of those 11 partners, five are under the age of 45, and they wholeheartedly went into this partnership. There was obviously long-term concern: Were we leaving something on the table by joining this? But you can't predict where ophthalmology will be in 5 or 10 years. Will the current private practice model still work? The ability to do premium surgery may not be sustainable.

For us, private equity meant reducing the risk for the people in our practice. Some of the junior doctors had a good feeling that they no longer have to buy me out when I retire. They can work with a clear conscience, knowing that there is no buy-out and no buy-in for them either. In addition to that, we reserve 15% of our equity pool for our

CASE STUDY: A MISMATCH OF VALUES

Private equity is not always the answer.

BY MATTHEW D. HAMMOND, MD, FACS

A few years ago, I sold my private solo practice and joined a practice that had just been purchased by a private equity group. I have now been an employee of that private equity group for the past 2 years. My comments are based upon my experience during that time.

First, know that I love the business side of medicine. I enjoy working and growing practices. When I joined my current practice, I anticipated that being an employee of private equity would afford me the opportunity to deliver care without the responsibilities of payroll, managerial issues, or other headaches associated with owning a practice. I found that the issues I no longer had to deal with as an owner were replaced by a new set of issues as an employee of private equity.

Private equity firms don't run a practice the same way a physician-CEO would. They run the practice with only the end goal in sight: to sell the practice and make money for their investors. By design, they have no real long-term commitment to the practice, to the patients, or to the doctors. For example, suppose you work in a high-volume refractive practice. One day, you are notified that the existing advertising budget is being cut in order to improve earnings numbers. Subsequently LASIK volume drops, as does your income.

In addition, the value of a future sale does not always align with the values of the physicians and their patients. The private equity goal of increasing profitability and growth in order to increase earnings before interest, tax, depreciation, and amortization for the end goal of selling the practice can be at the cost of physicians and patient experience. That is not to say that private equity–owned practices are not interested in patient care—of course they are. However, I would argue the bottom line is the metric by which the delivery of care is determined.

Private equity can be an attractive option for the doctor looking to sell his or her practice and retire; I say "retire" because, after the practice is sold, the owner will no longer have the control or role that he or she once had. This can be a drastic change and one that the seller may not be able to acclimate to for any number of reasons. One of the most difficult aspects for me was the fact that the board controlling the future of the practice was composed mostly of nonphysicians. I was used to making the decisions or at least being consulted before any change that could alter how I delivered care, how dollars were spent, how we strategically planned growth, or how we planned to increase volume. That changed with my new role as an employee, and I no longer had a voice in any of those decisions.

One case sticks out in my mind: I was forced to change to an electronic medical record that decreased productivity across all providers but supposedly was able to generate superior accounting reports—even though, in the end, that wasn't the case. We're a medical practice, not an accounting firm. One of the odd paradoxes occurred when my colleagues and I would bring data to the leadership suggesting changing small things on any number of fronts that would improve revenue. You would think that type of initiative would be welcomed and acted upon because it improves the bottom line. We're still waiting to hear back.

Private equity is a hot a topic right now. Most of the editorial copy I've read has been in staunch support of this movement. I understand that medicine is a business and that having equity investment can secure better insurance contracts, improved economies of scale, and improved facilities, among other things. These would be beneficial aspects of private equity if they were certainties, but they are not. I have not seen one aspect of private equity control that is better than what I could do as a solo practice owner.

I believe you must be in alignment with the people you work with. I am still working with this private equity group for another month, but my partner and I are leaving to start our own practice for the reasons just described.

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junior associates and new associates who come in, so that they will have investment in our practice going forward.

I still have a lot of regard for the young ophthalmologist who wants to hang a shingle and do it by himself or herself. It's risky, but I love risk, and I think that's something that should be encouraged. But for the average doctor right now, I think private equity is actually a lower risk opportunity than staying in private practice.

ESTABLISHING TRUST

Dr. Weinstock: Private equity in ophthalmology is still in its infancy. It is said that the horizon is 5 years, but we don't know exactly what that is going to look like. I have a colleague who was in a situation with his practice where there was to be a second bite of the apple, but there were really no bites left to take. The company that purchased his practice did not create value that they could then sell at a higher multiple, so they had to unload that asset for less than they paid for it. Then there were regulatory issues with regard to who took over the business. It led to a federal investigation and, unfortunately, it trickled down to the entities that the business owned, including my colleague's practice. Even though the physician did nothing wrong, but because he was associated with the company that was under investigation, it affected him. So trust is a huge issue when it comes to partnering with private equity. Would you agree?

Dr. Scoper: I certainly agree that it's all about trust. I look at it as if I were buying a new house. You take your time, go with your spouse, and look at every single house. You learn what you like and what you don't like. Then, all of a sudden, you walk in the front door and you know this is it. We had done so much homework and looked at so many private equity groups that we knew when we found a good cultural fit for us. We're all on the same page, and we feel confident that clinically this will not change anything at all.

We have four partners in our group. One is in the mid-40s and one just turned 40, and they were two of the most enthusiastic people about doing this deal. I feel safe for the future. We don't know exactly what's going to happen, but we all feel comfortable and are excited about it.

Dr. McCabe: Some of the younger partners enjoy the risk mitigation and having a larger financial structure around them. Having the opportunity for new associates to buy in is important. That can still be an option for them, but it is less risky. I think you get to have both of those opportunities available within your private equity arrangement.

Dr. Donnenfeld: It's all about due diligence and doing the homework. I would never work with a private equity company without knowing its track record. The first thing we did was talk to the five other practices owned by our firm and ask them about their experiences.

Dermatologists have been doing this for 7 years. Industry has been doing it for even longer. Outpatient, urgent care centers have been doing it for about 5 years. These have turned around, on average, to be about a three multiple on the investment. So private equity has done well on second sales in these areas, and this private equity model in dermatology is almost exactly the same as ours in ophthalmology.

INDUSTRY CONCERNS

Dr. Weinstock: I have heard concern from the ophthalmic industry about the trend toward consolidation. The worry is that economy-scale purchasing could drive prices down and negotiations up. Then again, it could also streamline things, and some companies may view this as an opportunity.

Dr. Donnenfeld: I'm working with most of the large companies right now, and they do view this as a concern, but they also see it as an opportunity. One of the things that attracts private equity to ophthalmology is our opportunity to charge patient-shared billing. We offer LASIK, multifocal IOLs, and laser cataract surgery. Hospitals and insurance companies have no interest in patient-shared billing. Private equity loves this, and companies are looking at this as an opportunity to grow their refractive portfolios.

WHAT HAPPENS AFTER 5 YEARS?

Dr. Weinstock: Our practice has acquired a few practices over the years. Every time we do that, there's a small dip in business when we have to add more staff or new equipment, for example. You have to spend money to make money. It's hard for me to understand the basic, big-picture math in this model, where you add practices into your portfolio, spend a bunch of money ramping them up, and then make them profitable in just a 5-year period. When we talked to private equity firms, they said they wanted to grow our business, spend marketing dollars, and increase market share. It costs a lot of money to do that.

Additionally, private equity companies have layers of management. Those positions all have salaries. That could be $400,000 off of earnings before interest, taxes, depreciation, and amortization (EBITDA) right out of the gate. I struggle to understand how this would all happen in 5 years—how the EBITDA is going to go up in the growth phase. I see the change taking at least 7 years.

Dr. Donnenfeld: The first thing that happens when you buy a practice is that you have economies of scale, which could also be called synergies. When we acquire a practice, the first thing they do is start sending us patients. That equates to about a 50% increase in revenue to a practice overnight, basically with just clicking a pen.

Dr. Scoper: When each of these individual practices in a private equity group grows, it doesn't boost just the EBITDA of the individual practice, but the enterprise value of the entire company. The whole enterprise value of a dozen practices together will be much more than that of a single, independent practice. There is synergy of these groups. We grow organically with each practice, and that increases the EBITDA for each practice. Every doctor in our organization is motivated to grow the EBITDA and grow the enterprise, and we're excited by this opportunity to work together. We're doing more than we could ever do on our own.

Dr. Weinstock: As for what happens after 5 years, my

CASE STUDY: THE BENEFITS OF LEADERSHIP

Choosing the right partner can help build trust and grow the practice.

BY EVAN SCHOENBERG, MD

I joined Georgia Eye Partners when I finished my fellowship in 2014. At that time, there were three equity partners in the practice, and I joined as an associate cornea specialist. I was on a traditional partnership track with the idea that eventually I would have the opportunity to buy into the practice as a partner. Along the way and prior to my buying-in, the practice went the direction of affiliating with a private equity firm.

Ours became the platform practice from which the EyeSouth Partners private equity endeavor expanded. I got in on the ground floor of this endeavor, investing in the new company in place of a traditional buy-in. I have no doubt that everyone's experience in private equity is unique, but, for me, being given the opportunity to invest as a partner and to grow into a leadership role was and is a big benefit.

Leadership is important. I am pleased that the EyeSouth board of directors is predominantly made up of physicians, and that individual practices within the greater company retain their identities and direction. This model allows substantial independence for each practice involved, and, as a result, I felt like the new model was an expansion opportunity and not something that would constrict or control how I could practice.

In fact, I've seen an expansion of support in areas that we, a medium-sized group practice, weren't able to bring to bear on our own. Working with private equity, we have hired someone to improve the efficiency and abilities of our technicians in the clinic. We were also able to outsource information technology services to a higher level than we had previously and to take on a big electronic medical record transition project that would have been overwhelming for us with the infrastructure we previously had. Our individual insurance coverage and retirement plan options improved, too, as we have a much stronger negotiating position as a large group.

It is important that the board of directors have physicians' interests in mind. I plan to practice for the next 30 years. What's this arrangement going to look like 2, 5, or 10 years from now? How will we be practicing when another company owns the business after the expected second sale transaction? This is a valid concern, but it's also a valid concern if you own your own solo practice or are a partner in a traditional practice. No one knows what medicine will look like 10 years from now.

Private practice is high risk and high reward; private equity from a physician's standpoint, on the other hand, can represent risk diversification and a shorter time horizon for potential reward. If my investment in myself and my practice proceeds as planned, I will see a far greater return on investment in the medium term than I would otherwise. Rather than buying into a practice and waiting 20 or 30 years before selling, I can leverage the time value of money and have greater resources to work with sooner.

Most private equity investors are looking at practices that have a long run ahead of them, so mid- and early-career physicians are involved as well. Ultimately, the company controlling the practice at the business level must still be aligned with the physicians delivering good care. It's unrealistic to think that some movie villain is going to purchase this practice, arch his fingers, and want all the physicians to be miserable. That is not compatible with good business. Happy physicians produce good results and good profits. This may be a leap of faith, but so is buying into a traditional practice (especially if that practice's business model is insurance-based!).

When I joined the original traditional practice, we were using microscopes that had been in use for about 15 years and previous-generation phaco machines. One of the first large capital purchases executed by the private equity–associated practice was the replacement of those operating microscopes and phaco machines. These purchases don't increase the amount of money we make per cataract surgery, but we know that they will improve our efficiency and surgical results. We've purchased new biometers and other equipment as well, and, in the past 3 months, built out a whole new beautiful office with expanded space, top-of-the-line slit lamps, and so on. My personal practice is growing, allowing me to provide better care, and letting me maintain focus on my favorite professional activity (surgery), without any personal debt at all, thanks to our private equity partnership.

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understanding is that there are other private equity firms with larger appetites than the ones that are buying practices. They're going to buy at a higher multiple because there's a higher EBITDA, and they will hopefully have a hands-off philosophy and you simply have a new owner. Nobody has a crystal ball.

Dr. Chu: One word that hasn't come up in this conversation is leverage. These firms don't use their own money to buy practices, but the practices that they buy have to cover the interest on the money they borrowed. So how is that covered in a negotiation process?

Dr. Donnenfeld: Well, that's what we call the *waterfall*. We do pay the interest on the loans that have been taken to buy other practices, and that is a risk, but that's the private equity firm's problem. If they can't pay, it's on them, not on us. One of the fundamental attributes of private equity is that interest rates can go up, and all of this becomes a lot more problematic and the multiples go down dramatically. There is a window of opportunity now with interest rates extremely low. When interest rates go up, everything will change.

STARTING THE JOURNEY

Allison W. Shuren, JD: When we work with clients at the beginning of this journey, we tell them they need to be clear about why they are considering a strategic partner. If this is going to be successful, you have to be clear and objective about what assets and experience you want a partner to bring to the table. This will help you vet partner options.

Money is obviously a big part of the discussion, but you are taking on a partner who will have some control over your business. There should be a meeting of the minds on what the parties hope to achieve together.

We hear a lot of reasons why people think they have to go with private equity. One is consolidation in the health care marketplace—a sense that you have to grow to survive. Another reason relates to the growing difficulty of running a practice efficiently and meeting all the business and regulatory changes that can feel crushing. There also seems to be a sense that the next generation of physicians do not want to own practices, so the pool of purchasers for your business may not be as you had planned.

It is important to understand that you are going somewhat into the unknown. That next purchaser may not be just another, bigger private equity group. It might be an insurance company or a health system. Are you okay with that? The goal of a strategic partner is to achieve an expected return on investment, so it needs to find a buyer that is going to make sense.

Dr. Donnenfeld: The most important thing that I consider, any time I do a business deal, is what my exit strategy will be if things don't work out. You need a good lawyer to help you with that. We have a surefire exit strategy whereby if I don't like what I'm doing after 4 years, I can walk away. I would lose my practice, but I could go down the street and keep practicing the way I'm practicing now.

Ms. Shuren: Private equity firms want to acquire your practice for a reason.

WHAT COULD PRIVATE EQUITY MEAN FOR INDUSTRY?

There are two schools of thought.

BY DANIEL YOUNG, SENIOR EDITOR

As a partner at Arnold & Porter, J. Matthew Owens, Esq, advises clients on all aspects of mergers, acquisitions, and divestitures. He has particular experience in health care transactions, and, with the recent interest in private equity investment in ophthalmology and other medical specialties, he has lately been helping physicians all over the country to negotiate transactions with investment groups.

"Everyone wants to know what the investment of private equity in ophthalmology will mean, both for the profession and the industry," Mr. Owens said in a recent interview with *CRST*. "There are incredible opportunities for physicians in this space, especially physicians looking for a succession plan. And for younger physicians who want to grow and expand but who don't have the capital needed, or who want relief from the burden of loans, this can provide an opportunity to find a financial sponsor that shares the same vision."

The mutual hope of physicians, private equity groups, and industry, he said, is that the resulting consolidation can have a positive impact on the specialty as a whole. Industry could benefit, as practices with greater access to capital may be in a better position to spend money on new equipment in order to provide a higher standard of care to their patients.

There are two schools of thought on the effect of consolidation on industry, however. "One says that a practice that has partnered with a financial sponsor with access to capital should be able to spend more on equipment," Mr. Owens said. "The other says, no, private practice physicians are more likely to spend money because they're the ones who actually want the equipment. When private equity groups call the shots, they will be more focused on the bottom line."

Medical device companies may now worry that they will have to negotiate more often with private equity, and that these groups have leverage that can drive prices down. Conversely, it may be easier to work with a group that is connected to 100 practices because it may want to buy a device for all 100 locations. "That type of volume might be worth the price of a discount. It saves sales representatives from having to travel to and negotiate with 100 different practices," he said. "I believe there's a world where private equity is more efficient for all parties, but we are still in the early stages, and it is too early to tell."

More generally, what impact will private equity investment have on the overall practice of medicine? Will new pressures on revenue be brought to bear? Or will the practice of medicine improve because physicians have greater access to capital and are relieved of management burdens? "The latter is to be hoped for, for the benefit of both the industry and the profession," he said.

You provide a service in a key location that is a strategic area for them to grow. Your goals are aligned. They want you to be happy so that you continue to do what you are doing. It's only if that somehow falls apart that there is a problem. Being completely aligned after 5 years makes you attractive to the next buyer.

Dr. Weinstock: One of the fundamental problems that we had with the process was that, if things didn't go well, we needed a way out. We would want to buy back the entity from the firm if it wasn't going well. We see this in the business world all the time. If I see a private equity company that will allow us to do this, that's the type of partnership I want because it creates a situation in which we have a safety net if things are not going well.

LEARNING FROM MISTAKES

Dr. Donnenfeld: Private equity got involved in ophthalmology about 20 years ago, and it didn't work out. The difference is that was a Ponzi scheme in which firms promised stock instead of cash. The idea was that, as the specialty consolidated and more practices joined the partnership, stocks would become worth more, but the consolidation never occurred.

Today, private equity firms are buying practices with cash. It is not a Ponzi scheme because you get value today. Also, the government and insurance companies are driving consolidation, and reimbursements are decreasing. In my view, the things that were anticipated 20 years ago that never happened are clearly happening today. Twenty years ago, it was a stock market play. This is an investment play. To be a private practitioner today, I think you have to partner with someone going forward.

Dr. Weinstock: I think we've learned from what happened in the past. It was all about stock deals, and there were no further buyers for those entities. The private equity firms will tell you that eventually their holdings will be held by pension funds that are looking for secure investments with low rates of return over long periods of time for their portfolios.

EFFECTS ON THE PRACTICE

Dr. Wiley: I know someone who once said, "Every Monday morning, I get a speeding ticket going to work. I'm driving as fast as I can to get to work. If I sold to private equity, I'm not sure that would happen." For those of you who have sold, are you still excited to go to work Monday morning?

Dr. McCabe: We were the first small practice acquired by our private equity group, and I had this perspective of wanting to do what we could to elevate the entire group. For me, it's a new perspective and something exciting, and it's not the way that I was looking at my individual practice before. I'm excited to figure out how to grow something in this model. Maintaining the quality of care for patients is a priority.

Dr. Scoper: We're all blessed to have a job that we enjoy doing. I always enjoy going to work, but maybe now I enjoy it even a little more because I have a bigger piece of that pie. When the enterprise value goes up, it's going to mean something to me financially that it would not have otherwise.

Dr. Chu: I think there's still a ton of opportunity out there for the non–private equity route. They wouldn't be investing in our sector if they were afraid of the future. So why are we afraid of the future? Even if it's a great cultural fit, private equity's incentive is not aligned with my incentive.

Sometimes, we do things that don't make financial sense to take great care of patients. The focus for private equity firms is return on investment. I haven't been able to get a satisfactory answer about how you resolve that difference in goals. I still think the future's bright. ■

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