SEASON 2, EPISODE 12

MEDICAL PRACTICE MERGERS & ACQUISITIONS WITH ATTORNEY GARY HERSCHMAN

David Mandell:

Hello, I'm David Mandell, host of the podcast. Welcome. Today we've got a special guest, one I'm excited to speak with, and who I think will have some great insights for those of you listening out there. So let me tell you about Gary Herschman, and then we'll bring him on. So Gary is the healthcare M&A, mergers and acquisitions, attorney and partner at Epstein, Becker and Green. Gary has been advising healthcare providers and businesses on mergers, acquisitions and other strategic transactions for over 25 years, and is known throughout the country as a top leader in healthcare consolidation deals. Gary writes and is quoted on this topic in many national public, including Bloomberg Health, Cranes, Beckers, Orthopedics Today, The Journal of Orthopedic Innovation Excellence, Fierce Healthcare and others, and is also a frequent speaker at healthcare industry conferences across the country, including the recent ICJR conferences.

In particular, he advises hospitals, healthcare systems, physician groups, long-term care companies, ASCs and healthcare technology companies on their most important and strategic transactions. So with that, Gary, welcome to the program.

Gary Herschman:

Thank you, David. Thank you very much for having me.

David Mandell:

And where are you today as we chat?

Gary Herschman:

Where are we today? I am in my home office in Spring Lake, New Jersey.

David Mandell:

Excellent. I know your firm is a national firm. Why don't you tell us a little bit about the firm in general, and then your particular practice. Give us a little background on the practice.

Gary Herschman:

Sure. Epstein, Becker and Green continues to be rated in the top 10 healthcare law firms in the country by modern healthcare. We have 340 attorneys in 20 offices

around the country. And half of those attorneys, about 170 attorneys, are healthcare attorneys doing healthcare regulatory work, and a lot of healthcare transactions.

David Mandell:

Got it. Makes sense. You guys are obviously one of the players. And maybe many of our physicians, I know you've worked on some transactions with docs who we know, who we have in common. And some of the folks might recognize you and the name of the firm. So tell us, this topic particularly is something that I know is on the mind of many physicians. Just spoke at a couple of conferences where questions came up on this, and other speakers are chatting on this topic as well. But in your words, describe the levels of consolidation or M&A activity in the physician space. What's going on?

Gary Herschman:

So, David, that's a great question. There's been a snowballing, if you will, in terms of volumes of transactions over the last six years. Back in 2015, and there are different sources for this, but I'm basing this on a Bloomberg compilation, there were 88 transactions. And there's been 20% to 30% growth in the volume of deals over each of the last six years. And in 2019, it broke 200 deals. It was 219 deals. Last year, the COVID year, the first COVID year, 2020, it came down, it was still over 200, but it came down slightly to around 208 deals. And already this year, through the third quarter, there were 245 physician deals reported in public announcements.

And the last quarter has been the busiest quarter of healthcare transactions I've ever seen. I believe that, as of the end of November, we're around 300. The final statistics will be out, but by the end of December, which as you know, a lot of deals try to close before the end of the year, I'm guessing that there's going to be around 350 deals, plus or minus, for the year, which would be a 50% increase over 2019. Just showing that there's just a ton of activity. And it really is, if you will, snowballing.

David Mandell:

We see in our practice, just by working with physicians on their either practice financial, health benefits, or for many of them, on the personal side, they come to us to say, hey, our practice is thinking about being acquired or they've been approached or what have you, what have you. So let's get into the why for a second. And I know this answer's going to take a little bit of, as lawyers like we are, an organized, like sort of A, B and C or 1, 2, 3. But what are the major reasons why physicians' groups are exploring these types of transactions? And tell us, I know we talked a little bit before we came on, there's kind of three reasons. Let's take each one separately, and then I can comment on it and we'll move through it.

Gary Herschman:

Well, I'll list the three and then we'll start with the first one.

David Mandell:

Perfect.

Gary Herschman:

Item one is monetization of the value of a medical practice. Item two are the future uncertainties and risks in medical practice. And number three are the benefits of being part of a larger group and larger corporate infrastructure.

David Mandell:

Got it. Okay. So let's hit those each. Monetization, number one. Talk about that.

Gary Herschman:

So monetization. And David, I know this is right up your alley. But I'm going to start off, when I'm presenting at national conferences, and I've presented this year at eight medical group boards as educational presentations, purely educational. And it's interesting. When I say this first item, people like, wow, I didn't realize that. But it seems obvious that a physician's ownership in their medical practice should be a major asset in their personal wealth portfolio, not just, yeah, they make a lot of money, hundreds of thousands or more. But their actual being an own owner, being a shareholder of the medical group, corporation or a member of the LLC is a real asset, or can be a real asset in their personal wealth portfolio.

But what happens is that most groups nowadays, it's different than the 80s and 90s. Most groups nowadays, they have a shareholder agreement or an operating agreement, or a partnership agreement. And when they retire or if, God forbid, they should become disabled, they don't get much in most groups nowadays. They get maybe their capital account, maybe 50% of their trailing accounts receivable, and some other small amounts that usually winds up to not be a whole hell of a lot and really doesn't equate to the real value that they own. Whether they're one of 10 owners or one of a hundred owners, it usually doesn't reflect that.

So doing a transaction with an investor or joining a larger national platform allows physicians to monetize the value of that asset, which they otherwise don't really see as part of their personal wealth portfolio. And with that in mind, what's the best time to monetize and lock in the value of something when the market is very high. So right now there are red hot market valuations because there's so much activity. There's so much activity because there's a $1.8 trillion of dry powder, which means money that is waiting to be invested in healthcare. And healthcare is somewhat recession proof, and everybody wants to invest in healthcare. So let's lock in the red hot market with evaluation. Let's do it at tax advantaged rates.

So there was a lot of talk earlier this year of potentially the 18% to 20% lower taxes of long term capital gains might go away in whole or in part. Well, it hasn't yet. But back in the summer and early fall, everybody, and that's why there's a lot of activity now, is trying to get this deal done before tax rates go up for long term capital gains. Which means, when you sell ownership in a company that you've owned for more than a year, like a medical practice, you would be taxed at almost a 20% lower rate. So the tax rates still haven't gone up. Could they go up in the future? Maybe. We don't know, but we know now they haven't. So everybody wants to try to do this because of the potential for increased taxes in the future.

And also, relating to monetization, it gives you the ability, when the market is high, to take chips off the table, like 70 to 80% of that value in cash and give it to someone like you, or whoever their financial advisor is, to invest. And then they get rollover equity. So taking chips off the table is smart because of future uncertainties, which we'll talk about in a minute.

The other thing that we talk about, because 20% or 30% is going to be rollover equity, like equity in this bigger organization, that's real rollover equity. That's real value too, because when you retire, if there's someone who's going to retire in the next five years, they get bought out at fair market value, at the real fair market value. So if the value of their ownership was two million, and they took 80% of it in cash, like 1.6 million, that other 400,000 will be bought out when they retire. Or if there's an exit transaction of the private equity company that's backing the investors, backing the platform, that usually doubles or triples in value. Not always, there are no guarantees. But that rollover equity every five years or so may yield further returns to the physicians. And so, those are the main kind of all in the category of monetization.

David Mandell:

I want to just comment on one piece of that really, which is the idea that the practice has value. And we've talked about this with our clients in our writing and our books, et cetera, for years, in another context. But it comes out the same, which is, in a practice, especially for S corporations, we have explained that you can save the Medicare tax by taking distributions rather than compensation. And that kind of makes sense economically because you take a certain amount of compensation as an employed or an employee physician, because when you're working for a practice that you own, you're also an employee of that practice, right?

Gary Herschman:

Yes.

David Mandell:

And you do work as a physician, seeing patients, et cetera. And there's a value to that. And that makes sense. Economically, you should pay. That's like a wage. That's your compensation. But then there's the whole category of compensation you get for being an owner. And that has been taxed differently, if you're an S Corp. And we see so many docs who don't A, understand it. And even their account is so conservative that they're taking it all as compensation, which is sort of making the recommendation or making the acknowledgement that the business isn't worth anything. You're getting paid everything as a W2. There's no value to the distribution because the company's not worth anything. It's all you, as you being the physician.

And we've always had an issue with that because we've always said that there is a difference between owner value and employee value. And in fact, you could hire another doc out of fellowship or from another practice and pay them a certain amount, but there still may be profit if you have a successful practice. And those profitable practices, and all the things we've talked about for years, in terms of how to have systems in your practice, how to processes, how to make sure it's marketed well, how to make sure its financial controls are there, that makes the profit even more and makes them even more attractive for this kind of transaction.

So we've talked for a long time about recognizing the difference between ownership and employee. I do it myself in my own business. You work for your law firm, but you're also an owner in your law firm. I work at OJM, but I'm also an owner. And we recognize that in our own professional practice. So I just wanted to make that point because it ties into something that's really nothing to do with M&A, but it's still the first recognition that there is a value to ownership. And there's a role to be played by owners that is not just seeing patients, working on the practice.

Gary Herschman:

And there is an equivalent, I'm sorry. There is a concept in these transactions, which is, let's say it's a specialty group. And let's just say, there's a doctor, because a lot of times they make different amounts of money based on productivity. But let's say there's a doctor who makes $800,000 a year. Let's just call it a urologist or whatever you may, a gastroenterologist. Like you said, if you can hire another person at 600,000, then that extra 200,000 is really your distribution as an owner. And that takes into account profit on other employees, mid-level practitioners, associates, ancillary services. And so, that's also the way a private equity transaction is looked at, is that your salary, your compensation, would be normalized to what is common. And that rest is kind of viewed almost as that income stream or profit stream that they're investing in.

David Mandell:

Yeah, it's exactly right. I mean, we're talking on the same page. So I know we've got two more factors here. I want you to go through them pretty quickly because I want

to keep, we have a number of questions, and I want to try to get to them through this in 30, 40 minutes.

Gary Herschman:

So the second issue, or the second reason, I should say, are the future risks and uncertainties in medical practice. And I'll just zip through these quickly. First of all, changes in reimbursement impacting Medicare and commercial payers. There have been Medicare downward adjustments of, I think most recently, 3.5%. And eventually, that trickles down to commercial payers and trickles down to compensation of doctors. So there are reimbursement uncertainties that could be further reduced in the future.

The second is heightened competition from hospitals and health systems and other big, large national healthcare companies. So let's say you're a specialist, whether it be an orthopedist or urologist, and you're in a market where the hospitals are buying up all the primary care doctors, which they have been doing for 15 years, or were Optum recently. Optum, in the, I think 16 or 18 largest metropolitan areas in the country have purchased the biggest primary care groups, and they continue. Hospitals and other large payer backed organizations are not only buying up those primary care doctors, but now they're starting to employ their own specialists, urologists, orthopedist, gastroenterologists. And so there is some risk because of that competition within specialties. There is risk that you're going to potentially lose some of that. So that's another reason.

And there's this continuous, but slow transformation to value-based payment and risk-based payments. And that is really happening. I know everyone spoke about it way back when Obamacare came out, and even before. But it's starting to really happen in a big way for a lot of specialists and primary care. A lot of primary care doctors are paid on a risk basis. And there's a lot of bundled payments for specialists. And so, changes in that may also impact your practice. It's another future risk.

And the last one is, just other changes in the marketplace, like the increasing number of large employers that are doing direct contracting. So they're not going through Blue Cross anymore, like the Walmarts and Amazons and other big companies are starting to do direct of contracting for specialty care and the like. And so, again, for strategic positioning, you might lose some patients in the future to any of one of these four or five reasons I just explained, with the changing marketplace and the future uncertainties that they cause.

David Mandell:

Yeah. Makes sense. And I think most physicians are aware of that. They see the future, or at least where it's heading.

Gary Herschman:

Yeah. And we have some clients that are still out of network, but they're starting to see that kind of coming to an end, the writing on the wall there. So even if you're out of network, you know you have to go in network. And if you're in network already, and you have been for some time, you're seeing some squeeze and changes going on that are impacting you.

David Mandell:

Yep. Makes sense.

Gary Herschman:

The benefits of being part of a larger corporate infrastructure. So, greater access to capital. So a lot of groups are saying, we need to expand. We need to open new offices, new ancillaries, an ASC, a second ASC, more imaging or start imaging and physical therapy, whatever it may be, and physician recruitment. So that costs capital. What that means for doctors is, it's less compensation whether they take it out of the pool or they borrow money and have debt service. What's nice is that, being part of a larger corporate infrastructure, the capital is provided by your larger partner.

Also, they are, for the most part, all the ones I've been involved with in terms of the groups that I've worked with have gone to platforms with large corporate infrastructure, like sophisticated executives for stewardship of the practice to deal with all of these future risks and uncertainties, better than just an office manager or a CEO versus an entire corporate infrastructure. Also, investment in the latest IT infrastructure, electronic medical records systems. And also, a key data analytics is very important in light of that transformation we spoke about to value based care, risk based contracting, and direct contracting. Having data analytics is important and it's all part of that whole IT EMR infrastructure. And it's real expensive.

Lastly, cost savings through consolidated back office functions. So those cost savings are, well, do you really need billing and HR staff for a group of 20 or 30 doctors when you're joining a bigger group that already has these whole teams? So there's a lot of economies of scale and almost higher quality in terms of back office functions, whether it be billing, collection, HR, IT, all those things. And similarly, lower costs of operating due to group purchasing. Even if you're a group of 50 doctors and you purchase malpractice very cheaply, you could probably get it even cheaper being part of a platform of 300 plus doctors. And even if you have over 150 or 200 employees, your health plan costs will likely be much lower if you're with a larger group that maybe has 500 or 600 employees all in. So all those things really add to more efficient operations and better outcomes.

David Mandell:

And those all make sense. I mean, some of it is sort of M&A and economies of scale 101, meaning it complies to different businesses. And others are really healthcare specific and not surprising. But those three things make a lot of sense to me.

Now we understand, I think we have a good sense of why practices are interested and why there's been so much activity as you gave us the numbers. From a doc listening to this and listening to you, obviously an experienced attorney in the field, you can, I think, give some insights to the other side. How do, generally speaking, investors value medical groups and what are the main drivers of value or where they see they could increase value in a practice? How are they looking at it?

Gary Herschman:

They're looking at it ... basically the most simple way to refer to it is free cash flow of the practice, otherwise known by investment bankers as EBITDA or earnings before interest, taxes, depreciation and amortization. The simple way to look at that, everyone's heard of that, it's in articles about this, but it's free cashflow. Basically you do your compensation normalization, which has to be at market levels. They don't want to invest in groups where the physicians take too low of ongoing compensation. It's got to be a good, normalized level in the market. Then they do what's called add backs, any one-time expenses and things like that. Interest, taxes, depreciation, amortization, they add that back also. They also add back if you had a lawsuit and you had $100,000 of legal fees. Some one-time events that you had to do, they add that back and then they get to a figure. Then, what they do with that figure, that's called the EBITDA or free cash flow.

Then they assess what's the appropriate multiple to reach the enterprise value. Multiples for smaller groups like five or less could be on the six to eight side, six to eight of multiple, but larger groups, let's say 10, 15 or more, would probably get into the eight to 11 range. Then bigger groups, more than 50, start to potentially get you, or even more than 25, into a range that could get you double digit which means anywhere 10 to 15 multiple.

It all depends, well, how do you know what multiple it is? The factors they look at ... before we get to that, let's say the EBITDA is 10 million and they think the multiple is 12 because it's a nice size group. Then the value would be 120 million, the enterprise value. If they see the enterprise value is 120 million, they usually will want to purchase anywhere from ... 70 to 80% would be the cash purchase price and the rest, you get rolled over equity in the platform. I'm just trying to think, in that example, let's say it was 100 million because I'm not a financial guru, if it was 100 million, there would be 70 to 80 million in cash depending on whether it's 70 or 80% or 75% in between and then the balance would be equity in the platform, the same equity the private Wall Street investors have. You know that you're going to do well as they do well. That's kind of the way it's calculated.

Some of the drivers of the multiple are the size of the group, which I've already mentioned, being diversified in terms of different subspecialties like a urology group that has all different sub-specialties within urology or cardiology, orthopedics. There's shoulder people, there's foot people, there's joint replacement. Having all the different sub-specialties within a specialty is important. Managed care is very important to many of the investors. They don't think out-of-network is really sustainable well into the future so they kind of discount that and they provide bonus … they don't discount it and you get full value if you do have managed care participation. They also look at your corporate infrastructure, especially if you're what we call a platform group. A platform group is the first group that an investor invests in in a particular specialty. If there's a big orthopedic group and they want to start with orthopedics, they invest in a group, that's called a platform, it's their first investment. Then the other groups are called add-ons or bolt-ons that come on to the same platform.

They do look at corporate infrastructure. They look at that more with larger groups, platform groups, than they do with smaller groups. They don't expect a group of 15 or less doctors to really have a great corporate infrastructure, but they want to know that there's a good office manager, someone that does HR work to follow the rules for all the HR policies and the information technology policies and HIPAA and all that. The last item, but it's very important, is ancillary services. They like ancillary services, meaning ASEs. Imaging, physical therapy, laboratory, durable medical equipment, all those ancillary services, cosmetics, things that are out-of-pocket paid, all of that all adds to how they look at the value and also the ability to expand.

David Mandell:

Yeah, that makes sense. We had a small investment banking firm on in the past year who represented some practices and that we've worked with. They reiterated a lot of the same things. Certainly obviously the EBITDA is the engine that everything rolls off of, but also I think I want to reiterate the points because we heard them again, ancillary being important, your payer mix being important and, especially for the large practice, which some of the folks listening may be part of, if they're going to be a platform, then other elements come into play. On the smaller piece it's probably more what you were talking about before where now you get cost savings, meaning we don't need the same management for the 15 doc practice when they've been rolled up that we need today because they'll be able to take advantage of the IT and some of the admin, et cetera, at the larger practice. Again, that's economies of scale and M&A 101. Good stuff there. Not surprising, but still good for people to hear.

Let's just, I want to fast forward just a little bit to say, okay, you're obviously an attorney, you get these deals done. This is something that the other speakers, other people we've had on haven't talked about because it's not their expertise, it's your expertise. Let's say we have a practice that has gotten an offer or a couple of offers.

It seems like the economics work, the docs are excited about it, maybe they're working with our firm to model it out, what it means for each particular physician as part of their personal financial life, meaning they're going to get a liquidity event now, maybe down the road, they may take less income. How do those things balance out? Where's the crossover? Et cetera. When do the attorneys get involved and what does that process look like, the transaction process? Give us a little bit of insight into what that looks like and what docs, especially those who are maybe in charge of handling this, maybe the management committee or something like this, what does it look like from their perspective working with a law firm and an attorney like you?

Gary Herschman:

Sure. Generally the first time we get involved is ... well, if there is an investment banker involved in the deal, we get involved early on, try to help the group make sure they have their legal house in order.

David Mandell:

I see.

Gary Herschman:

You know they're going to be due diligenced by potential investors. If there is an investment banker involved, which is usually the case with larger purchase prices where they shop and get competitive offers, we usually get involved at the very beginning. We provide input, make sure there's a good nondisclosure agreement before the banker discloses everything about your practice financially. We also review investment banker agreements upfront before the investment bankers are engaged and usually put in some protections to the group because sometimes the investment banker agreements say they get paid everything upfront, even on escrowed amounts and other things like that, and we always make adjustments like that and a few other things that ... you only get paid when amounts are released and the doctors receive it. You don't get your percentage on everything. There's a few items and, believe it or not, indemnity clauses in investment banker agreements that we look at.

Then, in addition to the nondisclosure agreements, we usually want to do a once over of their marketing materials that they're going to send out to potential interested parties just to make sure ... sometimes they're a little bit loose about certain things that have legal sensitivities, regulatory referrals and things like that. It's very minimal at that point, but really where lawyers get more involved, and even if investment bankers are not involved, if a group comes to us saying we're not using an investment banker, we have a great financial advisor and this group came to us and we know other doctors that went there, they're in our neighborhood or we see them at national meetings, they're very happy, the next stage is a letter of intent. A letter

of intent is really where the rubber hits the road. Actually I'm doing a webinar in three weeks just about letters of intent.

David Mandell:

Oh, interesting. Okay.

Gary Herschman:

Things to be careful about letters of intent. Sometimes investors or partners, big groups will say, "Oh, it's all non-binding." It does say it's non-binding except for certain things that are binding on the doctors like the standstill agreement or no-shop provision saying they can't talk to anybody else. What we like to do is … once you sign a letter of intent also, there's a lot of due diligence that goes on. It's somewhat disruptive. It takes a lot of time from your management team, sometimes the doctors, in responding to due diligence. Lawyers help with that and other financial advisors help with that and accountants, but it's just a lot of work. Then you start negotiating agreements. Hold that right there.

After you sign the letter of intent, there's a lot going on, a lot of time, effort, and cost. Freeze that. Go back to signing the letter of intent. You want to make sure before you start spending all that time and spending all that money, you want to make sure that all the key important terms are in this letter of intent. Even though it says it's non-binding, whatever is in there, everybody will always point back to it and say, "Well, it didn't say that in the letter of intent." It's almost like the constitution of the deal.

Like I said, we have a whole 45-minute session about this coming up but suffice it to say that it's important to involve legal counsel when you're negotiating the letter of intent. It's important that you get all the key provisions in there including non-competes and including how much of the purchase price is escrowed and things like that so you're not doing all this work and then, down the road, these issues come up and you're very upset. You wish you would've resolved them earlier and I think you have a little bit more leverage earlier because the investor wants to sign you up and stop you talking to others. Very, very important. That's the first major legal involvement.

David Mandell:

That's a really great point. First I want to talk about just the investment bankers for a second, because it is interesting, we've had some docs come to us. This obviously isn't what we do and they say, "Hey, do you think this deal's good? Who should I talk to?" Et cetera. Me, my background being a lawyer, talk to your lawyer or talk to a lawyer who knows this deal. Obviously Gary or somebody like Gary, right? You'll know what missteps you don't make early on. One of our lawyers talked on this

program and said there's a five dollar issue and then there's a $50 issue. They're often the same issue, but it's the timing. It was five dollars to do it in the beginning and now it's $50 to clean it up.

Now he was talking more about compliance not about deal making, but I do think I've been in enough, around enough businesses to really think that your insights on the LOI are really well taken. People should really hear that because, yes, it is non-binding, but I like your analogy of the constitution. As lawyers we know now it's all about interpreting that. Well, it wasn't there, but how did we think it was going to be? Yes, totally new terms can come in later, but you also don't want to spend all that time and effort if a new term comes in and, if you knew that in the beginning, you never would've gone forward. Now not only have you wasted all that time going forward, but now you've maybe taken yourself out of some other deals that could have been, that you could have talked to that you couldn't, because that was a quiet period.

Gary Herschman:

It's one of those things where it's better to spend more money. Even if it takes three or four weeks to negotiate the letter of intent and it's more legal time, it is so well worth that money because you'll bring out their position on the restrictive covenant and the escrows. You might not like it. Imagine if you learn that later. It's money well invested, just like the money on making sure your house is in order. Like you said, for compliance issues, it's good to also have a lawyer eyeball that and ask you some of the top 10 compliance issues that the investor's due diligence professionals look at because due diligence issues could cause devaluation.

David Mandell:

Sure. You've got to make sure your own house is in order before you even think about going down that road. Someone like you might say, "Okay, one of my colleagues who's healthcare compliance is really going to dig in and make sure everything's working on the car before we go out and try to sell this car, shop this car."

Gary Herschman:

That could be very cheap to do. Hopefully nothing is found, but no one's perfect. There's always little things, but hopefully there's nothing major.

David Mandell:

Right. Exactly. That point on the LOI I think is really important, because otherwise the optimists say, "Well, it's not there, but we'll probably get it later," and I'm always more skeptical of that. If it's not there now and it's a really key point, you can't

expect that the other side's going to go your way on every one of those points. I mean, that's just not the way it's going to happen. If it's not in the LOI or at least brought the parameters into some kind of tighter negotiation window, then you do all this stuff and it's like, wow, I had no idea they were going to come back with that. It's like, well, now we're here.

Gary Herschman:

They'll say, "Oh, all of our deals have a 15% escrow." No, that's not market. Or, "Oh, we can't tell you what the restrictive covenant is until we do due diligence." No, you don't want that. You want to bring these things to a head. Do a little bit of diligence now, it's not that much, to see what the restrictive covenant could be, because that is near and dear to doctors as you know. What I do think is nice about doing the more detailed letter of intent is it also brings out more of the personality of your potential future partner.

David Mandell:

Yeah.

Gary Herschman:

I always say that it can't just be about the money. The second or almost tied for the first most important thing about whether you move forward or not, and a lot of these deals might not move forward, is not only the monetary consideration and the factors we spoke about before, but the cultural fit. Are these good people? You'll meet them before you do a letter of intent and then you'll see some of their colors come out in a negotiation. It's very good to have a cultural fit and not just do this about the money. You might decide, a lot of groups nowadays are going through this process and then deciding when they see the offers, I thought it would be more, I don't want to give up business control of my practice just if it's that much money, plus I didn't find a good fit of people I liked and could see myself being partners with. That's also a good component of an LOI.

David Mandell:

I agree. We've said this before that, even if you went down that process and you did step away at least temporarily, your practice is probably stronger for it, right? You've gone through some of those compliance checklists to make sure we're in good shape. Maybe we've gotten a little bit of our corporate or legal house in order. We didn't file this or there are certain things that were loose ends and then we could clean that all up. The timing is everything. It could be that you go through this and, even though the space is hot, you don't find anybody right now, but that might change in six months or a year or two years. Yes, you'll spend some money to come through that process, but you'll also be, I think, a stronger practice for it.

Let's get, to wrap up here, big picture pros and cons. I mean, obviously we went through the pros of why people would do or consider these deals in the beginning. There was monetization, there was aligning with a larger institution which has both cost savings and maybe revenue enhancement because of your economies of scale and then there's also protecting against future downside which may be, being part of a larger group in case there's reimbursement decline and other risks to the practice, you're in a bigger boat and better protected on that. What are some of the cons? Give me a little bit of the pro and cons big picture in working with an investor based platform.

Gary Herschman:

Right. One of the cons you can avoid, which I've mentioned before, is make sure you have a cultural fit, that you know the people, that you've done your due diligence by speaking ... hopefully they would've invested earlier in eyecare, dermatology or other platforms in the past, talk to doctors that have partnered with them. Make sure that there's that cultural fit, because one of the cons could be that there's not this cultural alignment that you don't find out until you've already gotten married and done a deal. Also, you are basically saying you are yielding business control over your practice. I mean, the whole point is a lot of doctors nowadays, the younger doctors coming out, they don't even want to be involved in the business. More and more doctors I should say, not all of them. It is nice to some extent, but for certain doctors that have been active in the business aspects, sometimes it's hard for them to step away from that. Some want to step away and say, "Go ahead," but some, especially if they were one of the founders, it could be a little difficult.

You do lose business control, but one of the things that your attorneys will make sure is that you don't lose any clinical control, that no one can tell you how to practice medicine, that no one can implement medical, clinical policies and procedures, that the doctors in the group are directly in control of anything clinical related. Also, I always include interviewing and reviewing credentials of potential new hires. They can't tell me who is a good doctor. I want to be interviewing them. I want to make sure they're good doctors. Those are things that really, you do maintain control, clinical control.

Some of the hybrid issues, with some groups I'm able to get the consent of the doctors needed and others it's more of a mutual thing, are things that's very near and dear to doctors like electronic medical record systems. Some doctors are on NextGen or Cerner or Epic and they don't want to change. They hated doing it when they had to get trained on it, but now that's what they know and they don't want to change and be trained on a new EMR. EMR, we try to get ... any changes to EMR, we try to say it has to be a mutual decision or just get substantial input from the physicians on.

Also things like medical equipment. There could be certain types of surgical robotic systems or other instruments for in-office procedures and things like that where you don't want to be dictated. No, I like this equipment, I like this knee implant, I don't want to be told. Those are some of those things like that, which ... there's both sides of it where the doctor's input should be required but it's a mutual decision sometimes. We try to negotiate that to be, it has to be approved by the doctor. In the end, they want the doctors to be happy. They don't want ... happy doctors are more productive and talk up the practice. That's what they want.

David Mandell:

What's a takeaway thought for docs listening to this who may be thinking about a deal being approached, may have their friends tell them about something, what's your big picture, one thing takeaway?

Gary Herschman:

The takeaway is, if you do get approached, speak to an expert, speak to someone like you, David, who could help them assess it or potentially advise them to maybe get ... if they want to consider this, get an investment banker to not only get this proposal but to get a couple of others just for comparison purposes to make sure you're keeping them honest.

The other thing is, just real quick, I've been doing this, these physician transactions nonstop, more each year for the last eight years. What I saw two years ago right before the pandemic was maybe half of the doctors that I spoke to said, "I don't even want to consider private equity." Private equity is an evil word, bad, bad, bad. The other half would maybe explore it and then decide what they want to do if the terms are right and they feel like they have a good partner that they found.

Nowadays, what I'm finding, at least the last nine months or so as there's been so much activity, is that I see almost 80% of the doctors at least wanting to explore. Okay, before I say no, let me just see what I'm saying no to. The physician analogy is informed consent. You have to give your patients informed consent before you do a procedure. It's almost like you, the doctor group, before you say no to it, at least find out what you're saying no to. At least dip your toe in the water, see what offers there may be out there and then, if you don't like it, you don't like what you hear, you just say no and you move on.

The investment bankers just charge very small fees upfront to do this process, to see what the market offers would be and they also give, a lot of them give free appraisals or estimates of preliminary valuation assessments, but then they do the process. They get a little retainer, but most of their fees are on the back end on a deal closing. At least get informed before you say no, because I found a number of groups that still say it's not right for them, and it is not right for everybody, but I've found a

number of other groups that surprised themselves in the information they got and their decision to move forward because they were surprised by it. Again, it's just a matter of getting informed is my takeaway.

David Mandell:

Yeah. I think, in my opinion, that might be for two reasons why I think more are coming around. One obvious one, maybe most obvious, is COVID has just been tough for everybody, especially in the healthcare field. Burnout is high and people are like, "Listen, if I can shift the business part out to someone else and get a liquidity event, maybe that sounds pretty good. I don't have to do everything as much as I used to." The other part of it, I think now that we're years into some of the deals, some of the first movers, their friends, they can talk to. How'd it go? How is it going? If they hear good to decent stories, they say, "Well, maybe this isn't so bad. Maybe I thought, my assumptions were that I was going to work three times harder or that the investors were going to tell me how to practice medicine, that didn't come true with my buddy and their group. In fact, they're pretty happy with how things have gone." Now they say, "Well, maybe I'm more open to it."

I think in the beginning you talked about a snowball. We don't have that down here in South Florida where it's 75 degrees today, but it is a little bit of that effect even within the community. You get some success, people hear about it and, if there's more happy stories than horror stories, then that should feed itself. I think that's a positive development.

Thanks so much for being on. I think it was great. I'm sure we'll have you on again. I think there are some topics we didn't even touch that we will get to. For everybody listening, we will have in the show notes, as we always do, Gary's full bio. We'll have his email there so you can contact him directly. His firm obviously is a big one, they work with clients all over the country. If you feel like this is something you're going to step your toe into or that you already are, having a good attorney, and I say this as an attorney, to me is a key success factor. We talked about today some reasons why including what I thought was a really good and interesting discussion on the LOI. With that, Gary, thanks a lot for being on.

Gary Herschman:

Thanks for having me on, David. Great.

David Mandell:

Thanks for everybody for listening. As always, in a couple weeks, we'll have another episode. Thanks for tuning in. Tell all your friends. Thanks.