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To Sell or Not to Sell? Private Equity Investors Have an Eye on Retina Practices

Have you been approached by private-equity investors interested in buying your practice? What opportunities—and drawbacks—could selling your practice offer you? On a larger scale, what is the role of private equity in the future of health care? The cyclical nature of the health care climate and private equity investment offers us a timely opportunity to investigate these questions.

In our search for answers, Retinomics turned to Gil Kliman, MD, MBA—a fellowship-trained California retina specialist and managing director of InterWest Partners' health care venture capital team. His education, training, and atypical career path give him a multidimensional perspective on the flow of investment money into the purchase of medical practices.

Gil is in a unique position to understand why the recent wave of private-equity investment may be different than in the 1990s. Who better to discuss this topic than one of us?

Gil Kliman, MD, MBA
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Richard Garfinkel: Gil, as a venture capitalist, please explain the difference between venture capital and private equity.

Gil Kliman: The terms *venture capital (VC) and private equity (PE)* are used fairly broadly and sometimes interchangeably, but they're 2 different types of investment capital with different strategies.

VC consists of institutional capital funds oriented toward technology-based, early-stage companies. It's a technology bet; by investing early, you're hoping to get an exponential increase in value through development of the product and ultimately attaining Food and Drug Administration (FDA) approval or successful commercialization.

VC is a 5- to 10-year process, and it's a swing-for-the-fences game where you're going to make, 5, 10, 20, sometimes 100 times return on your investment—but it's fairly high risk and usually based on technological innovation.

PE is a very different game. Like VC, it is composed of capital organized into funds—but PE invests in established businesses, and many PE groups stipulate that the businesses they invest in have to be profitable. So PE invests in a different part of the business cycle than VC. PE makes money by helping established companies grow faster, primarily through financial engineering and arbitrage.

Unlike VC, which is driven by novel technology, PE strategy is based on identifying a proven business and then making it much more valuable. The strategy could involve leveraging operations with debt or gaining economies of scale in putting businesses together. It could be an arbitrage play where you consolidate private businesses so they can become more highly valued as a public company—a tactic commonly called a *roll-up.* It could also involve changing management or even breaking up companies if the pieces are worth more than the whole.

Larry Halperin: Gil, please outline your career since completing fellowship and starting in the business world.

> **'Venture capital [is] ... oriented toward technology-based, early-stage companies.'**

What is *arbitrage?*

There are academic finance definitions, but in practical terms for this discussion, arbitrage is buying a company and then finding a way to have it immediately valued higher. The most common example of this would be taking a private company public to get a much higher earnings multiple.

Gil Kliman: First, I loved ophthalmology and retina. During my retina fellowship at Massachusetts Eye and Ear, I started doing laser research in the early days of photodynamic therapy (PDT). The first PDT for macular degeneration was done in 1988 by my research group in Carmen Puliafito's lab where I was a research fellow. That was at the beginning of a giant evolution in pharmacologic treatment of retinal disease that exposed me for the first time to scientific entrepreneurs and technology innovation. I was curious about how I could work more with ophthalmic technology innovation and maybe not see patients full-time.

> 'Unlike VC, which is driven by novel technology, PE strategy is based on identifying a proven business and then making it much more valuable …'

Since I had always been focused on academic ophthalmology, I didn't know anything about business so I had to learn about what business tracks might be available to an ophthalmologist. Also, I didn't want to leave ophthalmology precipitously, as I really liked the field—so I worked out a deal to practice part-time at Mass Eye and Ear (and later at Tufts New England Medical Center when Dr. Puliafito became chairman there). I then set out to find a part-time business job that would let me learn more about innovation.

I sent out 30 resumes and cover letters to various financial groups that were investing in health care companies, and I received 29 "Dear Occupant" letters. But I got one phone call from Bob Daly, a senior partner at TA Associates, a Boston-based investment fund that today is one of the most successful, well-known PE groups. At the time, they did both early-stage VC and later-stage PE investing, so it was an amazing platform for learning.

The only reason TA Associates hired me was that they had never employed anybody with a medical background. They were all MBAs and general business executives, and they wanted a doctor to work in the group. Bob and all the partners at TA Associates were incredibly generous and gave me a part-time associate position while allowing me to continue to see patients.

I had no business experience and no MBA, but they said, "We'll teach you something about business, and you can teach us something about medicine." Working for TA Associates was a great 3-year experience, essentially an investment fellowship taught by blue-chip investors. And it showed me the difference between VC and PE, because some of the things I was looking at were very early-stage start-up companies, and others were more like what's going on today with roll-ups and health care services.

I was involved in many PE health care service investments in the early 1990s, most of which were managed care or physician practice management companies (PPMCs). One very successful investment we made at TA was in a small, private company that became HealthNet. Another was a Texas oncology group that became one of the first successful PPMCs. It was an amazing first exposure to the business world, especially for a parochial ophthalmologist.

However, I felt like I was doing surgery without having taken anatomy; my undergrad degree was in biology, and I had never taken a finance course or Econ 101. In 1992 I was fortunate to get into Stanford Business School for a 2-year MBA program, and when I graduated in 1994, I was lucky enough to be in Silicon Valley for the wild ride of the dot-com boom, which was an education in itself. I joined InterWest Partners to do early-stage health care VC, and that's where I've been for the last 20 years.

Richard Garfinkel: In the 1990s, there was a climate similar to what we're seeing now, with PE buying physician practices and management groups being established. What similarities do you see?

Gil Kliman: As Yogi Berra said, it's déjà vu all over again. Today we have the same macro situation, with forces at work that may threaten physician practices and offer advantages to consolidation. I think in the 1980s and '90s, it was more about trying to gain leverage against managed care. Insurers were consolidated first, and they mostly became health maintenance organizations (HMOs). In reaction to that, PPMCs tried to aggregate to gain negotiating leverage against HMOs. But that was a very unsuccessful area for most PPMCs in the last cycle.

Now I think there is another wave of consolidation in health systems, and that's driving physicians to band together. The "free-range" physician is disappearing; the solo or small practice is becoming just a remnant of the previous health care system. People are aggregating into large practices and multi-specialty practices, which can now be consolidated into larger entities that might gain negotiating leverage and economies of scale vs the health care systems and payers.

Richard Garfinkel: So, the health care climate creates the right conditions?

Gil Kliman: Yes, and it's about business negotiating leverage. As businesses get larger, they gain leverage—so in the HMO cycle in the late 1980s and '90s, the indemnity payers consolidated and changed to the HMO business model, which put a lot of pressure on provider reimbursement. Then, as a secondary phenomenon, the providers attempted aggregation in PPMCs to have larger blocs for negotiating fees with payers.

Larry Halperin: And so, in the 1980s and '90s, a lot of deals that looked attractive to the practices ended up falling apart and lawsuits ensued, with all kinds of challenges for the practices trying to extricate themselves from the deals. Why didn't those deals succeed?

> 'The "free-range" physician is disappearing …'

Gil Kliman: I think the investment hypothesis, at least of the PE people who were forming these deals, was that you would be able to create truly consolidated businesses with economies of scale not available to the individual practice. That way, you could bring in increased contracting sophistication, you'd have a much larger group that could add more leverage in pricing, and that would allow you to hire more sophisticated people to negotiate and analyze things like managed care contracts and supply procurement.

Also back then, there was a big promise about health care information systems—it was just called *HCIT* before the digital health revolution; there were going to be practice management systems brought in by the corporate parent of these consolidated entities that any individual practice couldn't afford to build or buy on its own. You would have much more sophisticated billing visibility. You'd have an electronic medical record and have a more scaled business

infrastructure that you couldn't afford as an individual private practice.

Then finally there was the seduction of the arbitrage play. A physician could sell an individual practice for only a very small multiple of earnings before interest, taxes, depreciation, and amortization (EBITDA). It was generally a low multiple of 2, 3, maybe 5 times EBITDA.

But if you rolled all this up into a large public entity, you could be valued at 20, 30, sometimes more than 50 times earnings as a public company if you were growing fast—and for people who had equity in the parent company going public, there would be tremendous economic benefits beyond the up-front economics of having a private practice purchased.

Richard Garfinkel: What was the problem with these roll-ups?

Gil Kliman: The most common problem in the late 1980s and '90s was that there wasn't true consolidation. The practices were being consolidated financially into a roll-up so they *looked* like they were all one business—but they continued to operate the way they did before, and there wasn't a lot of change of workflow.

The IT systems that would integrate them all were not really implemented, and the roll-ups never achieved true economies of scale. That caused the people who had sold their practices to be disappointed by the value to the practice being offered by the PPMC.

The other issue was a "tragedy of the commons" phenomenon often seen in roll-up strategies, where the business dynamics deteriorate as acquisition activity rises. At the beginning of a roll-up, you can buy practices at reasonable multiples, but as the game gets more competitive and more acquirers enter, the multiples you have to pay for practice economics go up.

> 'The most common problem in the late 1980s and '90s was that there wasn't true consolidation.'

That rising cost causes the arbitrage opportunity to go down for the parent company—so the PPMCs ended up overpaying for some practices, often largely in equity rather than cash, and the people who sold later in the cycle got stock that ended up being low value. The PPMCs then didn't really grow and most failed, and people got into all the issues you talked about—having to unwind their practices, filing lawsuits, etc.

What's different now? Is there going to be true consolidation? Will the acquirers actually integrate these practices so they benefit from real corporate economies of scale? Will they be able to provide the IT infrastructure—which is now much more ubiquitous and much easier to provide than it was 20 years ago—to bring value so that the practice, when integrated into a larger entity, is truly producing much more value than it would on its own?

Richard Garfinkel: Then one key to a successful roll-up is a true single practice as opposed to each practice doing what it continues to do under one umbrella?

Gil Kliman: Yes, it would be ideal to have true integration in a traditional business structure. But I think there are challenges in that physicians by their nature—especially ophthalmologists—are used to running their own show, and they have been very successful in doing it.

Becoming employees and following a corporate plan may not be exactly what the physicians were doing before, and there might be changes in the numbers of employees. The practices might have to operate with fewer or different types of employees, and there would be a transformation in how the businesses are run.

Many ophthalmologists, at least in my time, went into ophthalmology to be able to control their own destiny. It's one thing to merge practices into large groups that are all retina specialists; they're still controlled by the physicians. But when you start talking about being part of a public company that's reporting quarterly and is run by pure business people, it becomes more of a Fortune 500 employee dynamic, which has always been challenging for physicians to thrive in because it's just not the environment that most physicians desire.

Larry Halperin: Gil, in the 1980s and '90s, practices were purchased by private equity. Where you were in this cycle determined the multiple you received. Most of these roll-ups crashed and practices bought themselves back for a fraction of purchase price.

Gil Kliman: Yes, but it seems to me that all that disruption is a hard way to make money!

Larry Halperin: Gil, it seems that some people imagine entering these deals just to make some money up front, and then to buy the practice back for cents on the dollar after the buyer fails. What do you think of that thought process?

Gil Kliman: I hope that is never the thought process. A "flip" should never be the reason to go into a business relationship; I can't imagine the pain and suffering that would cause.

To be more optimistic, I think a well-run PPMC could end up being a practice improvement and a positive economic experience for the ophthalmologist.

> 'A "flip" should never be the reason to go into a business relationship ...'

As an ophthalmologist, I'd be looking for a good team of business people who could transform my practice, bring in true economies of scale, and make it into a public company someday where there was a good equity play—but where I could still have my personal practice of ophthalmology be enjoyable. I think that would be fantastic, because one of the big things missing in medical practice is an equity play.

I'm looking out my window now at start-up companies in Silicon Valley—everyone is getting a salary, but they also have stock options where if the company's management team is successful, they could make millions of dollars without doing any additional work—and physicians deserve that same opportunity.

It takes a sophisticated, seasoned team to make a physician business work in a way in which the equity can be sustainably valuable. In the last bubble in the 1990s, probably for a year or 2, there were several billion-dollar

What is a *tragedy of the commons?*

Tragedy of the commons is an economic theory describing a scenario in which all individuals have equal and open access to a resource, and each person tries to reap the greatest benefit from it—thereby neglecting the common good of all users through the pursuit of personal gain.

Source: Investopedia. https://en.wikipedia.org/wiki/Tragedy_of_the_commons. Accessed April 25, 2017.

market value PPMCs. The people who got in early were probably able to sell some of their stock in the public markets, make a lot of money—and then everything collapsed and hopefully they got their practices back.

I think people who got burned the most were those at the end of the cycle who sold their practices for a good percentage of stock, and the stock never was worth anything or they couldn't sell it before it collapsed. Then they went through a restructuring and ultimately got their practices back, but probably felt like they had gone through a messy divorce.

Richard Garfinkel: Then what's the view from the PE side?

Gil Kliman: The best PE funds get a very good management team involved. We used to do this at TA Associates; find an experienced management team that's done this before, and give them capital—a lot of capital. It may take a couple hundred million dollars to really get up to the scale of a business suitable for an initial public offering (IPO). And the team needs to buy the right practices at the right price.

The PE firm is betting that their team can do that and then be able to take that company public for multiples of their cost. And unlike VC—we're still trying to hit home runs where we get a 10x or 20x—they're generally trying to get a 3x to 5x on the money they have invested, which can happen faster than the 5 to 10 years it takes for VC success.

'One of the big things missing in medical practice is an equity play.'

PE can be one of the most predictable investment businesses. People who are good at it make money consistently year after year through buying small businesses, turning them into bigger ones, and doing financial engineering on them. The "A" player PE groups all have proven records doing this. The problem often is that there are many PE funds of varying experience, and due diligence is critical to ensuring they can deliver on their promises. That is where retina specialists looking to sell their practices should do the most due diligence. Who is on the PE team? Who's buying the practice? Do they know how to do this? Have they done it before? Do they have a track record of success? And who are the financial investors, ie, where is the money coming from?

Often, these deals need a lot more money than the initial plan called for, and deep pockets and committed management are required to make them successful. Top PE groups have large funds and generally can also attract blue-chip management teams that really know how to operate a business. That's not saying that some smaller or lesser-known groups couldn't do it, but I think there's more risk.

When you have an inexperienced investor and management team, the team might not execute, and the investment group might not have enough capital to keep everything going long enough to continue acquiring at a level where they could take a company public.

Richard Garfinkel: How do you vet the management team?

Gil Kliman: Here is a checklist of things to consider:

- ❑ How strong is the team? Do they have proven CEO, CFO, COO?
- ❑ Have they done this business, or a business like it?
- ❑ Have they worked together before? It's always higher risk if execs are being brought together for the first time.
- ❑ How detailed are their presentation and business plan?
- ❑ Can they answer questions crisply?
- ❑ Are they asking you the right questions about *your* practice?
- ❑ Who's giving them the money? If it's a name-brand PE fund backed by institutional investors, that's a big positive. If they're individual investors, it's riskier.

Larry Halperin: Gil, in a perfect world, a retina practice could sell itself for a good multiple, and have an equity play through owning shares of the larger company. Separate from this, could this process make a practice that is stronger, better, more successful? Could it provide better patient care? Is that possible in this private equity world? And if so, is now the time it could happen?

Gil Kliman: Absolutely, yes, it's possible, and that's why I'm glad people are trying this again. That's the reason you would want to do one of these deals. There have been many other cases where consolidating into a larger business produces a much more successful company. I think if you search Fortune 500 companies back to their roots, they started out as small, private companies that went through aggregation and consolidation. The mighty Alcon started as a corner pharmacy in Fort Worth, Texas.

'At start-up companies in Silicon Valley, everyone is getting a salary, but they also have stock options ... and physicians deserve that same opportunity.'

I would argue that ideally, for an ophthalmology PPMC, it would be a multispecialty format—more than just putting together retina practices. I think the Holy Grail has always been integrating and having a corporately managed multi-specialty group with cross-referrals—at least multiple ophthalmology specialties.

Larry Halperin: Yes, I think their idea is to come into a neighborhood and buy a big retina practice, along with general practices, subspecialty practices, and optometrists, and put them together into one big corporate entity.

Gil Kliman: Exactly, and this is a recurring dream. It was the dream in the previous cycle with companies like MedPartners and PhyCor trying to create huge value through a multi-specialty model. But it may be that eye is its own separate entity and the integration is across just eye care, as Physician Resource Group (PRG) and others tried to do unsuccessfully. So, that vision of an integrated eye center in a more corporate setting is still unfulfilled, but resiliently attractive.

Richard Garfinkel: Does the buyout work equally well for the older partners and the younger doctors in a practice?

Gil Kliman: There are some inherent differences in aspirations and incentives for different generations of ophthalmologists, and this has been a source of conflict in the past. I think what caused some of the last-generation companies to blow up was that there weren't proper financial incentives.

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The older partners got paid a lot up front and then had a smaller financial incentive to keep seeing patients, but they were nowhere near as motivated as when they owned the practice.

The younger people had some upside incentives but not the big up-front payment, and it wasn't as much of a reward as if they were going to be taking over the original practice themselves, which is probably why they had joined the practice in the first place.

I believe a thoughtful buyout model can work for everyone if the right incentives are put in place. These are all deal terms that can be addressed and solved in this next generation of PPMCs, which hopefully will focus on this key aspect of the transaction.

Larry Halperin: For this to work, doesn't it have to be good for the PE, where they're going to build something that's going to be profitable? And doesn't it have to be good for the practices to be able to provide even better care? And doesn't it ultimately have to be better for patients, so they're going to get the best care possible at the most efficient cost because somebody built something that doesn't exist right now?

Gil Kliman: Yes, exactly. This can't be just a financial transaction that's prettied up to go public so people can make money. That always fails, and any time somebody starts pitching you something with that kind of flavor, with an emphasis on quick roll-up and IPO, run, do not walk away; you don't want to be involved in that relationship.

In the first hour of talking with some of these PPMC investors and executives, you can probably tell which ones are more experienced and more long-term focused vs those who are just trying to put together a financial transaction to make some quick money.

Good PE groups will want to build a real company that's around 10, 15, 20 years from now—not something that's a quick flip. The best investors will try to build a company that truly adds value to the ophthalmology practice and has short- and long-term economic value to the selling ophthalmologist. Any future IPO is a byproduct of success, not a goal in itself.

We thank Gil Kliman for taking the time to answer our questions and to provide us with a clearer understanding of the potential role of private equity in the future of health care.

Financial Disclosures

Dr. Garfinkel – COVALENT MEDICAL, LLC: Stockholder, Stock; NOTAL VISION: Consultant, Honoraria.

Dr. Halperin – COVALENT MEDICAL, LLC: Stockholder, Stock, Other Financial Benefit; REGENERON PHARMACEUTICALS, INC: Consultant, Honoraria.

Dr. Kliman – AVEDRO INC: Board of Directors, Stock; GLAUKOS CORP: Board of Directors, Stock, Stock Options; GOBIQUITY INC: Board of Directors, Stock; REVISION OPTICS INC: Board of Directors, Stock.