According to the most recent AAOS census survey, 48 percent of orthopaedic surgeons work in the private practice setting, with 12 percent in solo practice and 36 percent in some type of group. Fifty-one percent of group practices employ 10 surgeons or fewer. The surgeons in those groups manage both the clinical and financial aspects of their medical businesses, and many have diversified service lines with imaging, physical therapy, urgent care, and ambulatory surgery centers (ASCs).

Despite increasing volumes of orthopaedic disease and service line diversification, practices are experiencing negative income pressure because of third-party reimbursement trends that have been cutting the value of orthopaedic surgical work for 25 years. Increased costs related to technology requirements and governmental regulatory mandates have made it even more difficult for smaller practices. The COVID-19 pandemic exacerbated this trend with office closures, moratoria on elective surgery, and patient reluctance to engage in the healthcare system in general. Also, practices that have been very successful in building vertically integrated musculoskeletal businesses and capturing significant market share are challenged to seek new avenues of growth because of limitations of scale and geography. They are looking for new and innovative ways to grow their practices without loss of autonomy or practice identity.

There are limits to the private practice business model, most notably in capturing significant future value. The private practice orthopaedic surgeons spend a lifetime developing, growing, and nurturing their businesses and rarely see any equity from that effort besides their personal incomes. Geographical or practice geographic disparity does not play a significant role in the valuation methodology. As with many things in medicine, the local practice environment may preclude certain types of consolidation as an option. Private equity has been involved in medicine for several years, with purchases in dentistry, oral surgery, dermatology, and ophthalmology. Purchases of orthopaedic groups began in 2017 and have accelerated recently (with some interruption from the COVID-19 pandemic). Private equity brings capital and business acumen to the valuation, purchase, and implementation phases of an equity sale or “event.”

Structure

The structure of a private equity purchase of an orthopaedic practice creates a limited liability corporation known as a medical service organization (MSO). The MSO owns all nonclinical assets of the practice and is in turn owned by the private equity group and surgeon partners. Each partner group then signs a business service agreement with the MSO to provide services. Percentage ownership of the MSO can vary depending on the scale of the investment by the partners and the timeframe of the purchase of the practice. Share class can also vary but usually is equal between the private equity group and surgeon partners to align incentives for improving future value.

Each partner practice maintains its name, branding, and tax ID, which facilitates the post-closing transition, avoiding billing and collections delays and the need for recredentialing. Billings and collections can be performed at the MSO or practice level depending on the given private equity model. Other purchasing, information technology, and human resource (HR) functions can be similarly centralized or broken up for individual consideration depending on the desire or need to leverage scale, but these are model dependent. The goal is to minimize disruption and stress in the transition to avoid productivity and income issues.

After initial discussions under a nondisclosure agreement, a decision to move forward with valuing the practice takes place, and a letter of intent (LOI) is signed between the practice and the private equity firm. The LOI usually stipulates exclusivity in negotiations for the practice and the private equity firm.

Valuation

The valuation process is usually conducted by the private equity firm and overseen by an independent third party for objectivity. A practice should also consider a separate consultant for evaluating value as a check to ensure its interests are upheld. The practice is valued according to accounting standards and Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA). Because most practices show no retained earnings, various methods are used to add back value to arrive at an adjusted EBITDA, which is used to calculate a multiple that reflects the market value of the practice. The private equity firm is able to realize the value by leveraging a certain percentage of future earnings of the surgeon partners to create an upfront dollar valuation of the practice. The surgeons forgo that income in return for realizing it upfront at the closing of the sale. The value is usually distributed as a combination of cash and ownership in the MSO. The upfront cash is taxed at capital gains rates, and the MSO ownership interest is tax deferred, adding to the value of the transaction. By valuing and distributing the cash and equity in this manner, the private equity firm is able to provide several years of income for the surgeons at closing that is not exposed to the risks of the current practice environment.

As an example, surgeon income is set at $1 million, and the future earnings used to create value are 30 percent, or $300,000. Future yearly earnings for the surgeon will be $700,000 post-closing. The $300,000 future earnings are then multiplied by the EBITDA-derived multiple, which in this example is seven, for a total valuation for the surgeon of $2,100,000 at close of sale. This sum is then distributed in some combination of cash and ownership in the MSO. In this example, 70 percent is distributed in cash and 30 percent in the MSO. The surgeon receives a check for $1,470,000 and rollover equity in the MSO of $630,000. At future sale of the MSO, the surgeon realizes value based on his or her ownership. In this example, the future sale (equity event) realizes a conservative three times return for a sum of $1,890,000. Total value to the surgeon based on the $300,000 per year future earnings sum is $3,360,000 ($1,470,000 + $1,890,000) in pre-tax dollars. The second equity event is made four years after the initial transaction, the surgeon leverages $1,200,000 in income for the $3,360,000 return. This is an example only and is dependent on the specific model offered by the private equity partner.

Growth

The MSO is a structure intended to facilitate top-line (increased collections) growth. Both the surgeon and private equity partners are incentivized to create same-site growth and add other practices to the MSO. Same-site growth is created through organic increases in patient and surgical volume, as well as the addition of ancillary service lines. The surgeon partners determine the need for the addition of new surgeons and ancillaries and can be assisted by a market analysis performed by the MSO. The capital necessary for hiring new surgeons and for building out and staffing the ancillaries are borne by the MSO, and profits are shared between the MSO and the individual groups that add the surgeons and ancillaries. Both the MSO and partner...
surgeons play a role in identifying and vetting like-minded orthopaedic groups to offer partnership in the MSO. Through same-site growth and practice acquisition, the value of the MSO increases and becomes attractive to other buyers in the market.

The MSO can also leverage size in payer negotiations and purchasing to create value. Data collection of both economic and clinical outcomes can be assembled at the MSO level to assist in demonstrating value for compliance (MIPS), contracting, HR, purchasing, and value-based care programs. Best practices and novel service lines can be exported to partner practices within the MSO to further increase value. All practices do something that others don’t, and ability and incentive to share business and clinical expertise among the partners are real benefits of the MSO structure.

Concerns
The concerns surgeons have about private equity acquisition are related to loss of business and clinical autonomy, income reduction, and the uncertainty presented in future equity events with changes in ownership. For orthopaedic surgeons, it is important that the operating agreements with the MSO maintain surgeon control of all clinical decision making and provide for continued governance in the MSO structure to mitigate concerns of autonomy. Income repair (bringing surgeon compensation back to pre-sale level) is essential and is a function of the growth strategy of the MSO. A plan for that growth should be a focus of the due diligence process prior to closing. Once again, this stresses the need for a cogent reason and plan prior to engaging in discussions with private equity firms. Future equity events are attractive from an ownership standpoint but create uncertainty with autonomy and governance. These concerns can be addressed in the operating agreements but also with the realization that if the partner surgeons do not value a potential buyer, they can withdraw from the transaction. This decision, of course, decreases the value of the MSO, so it incentivizes buyers to take a physician-friendly approach in considering MSO purchase and ownership. Concerns of cost-cutting maneuvers driven by private equity profitability mandates have been experienced in other medical specialties. This issue can be avoided by a commitment to top-line growth by both the surgeons and equity partners. Operating documents that codify alignment of incentives and strategies for growth can ensure that growth is driven by increased volumes, ancillaries, joint ventures, and practice acquisitions—not by cutting staff and supplies. Another concern has been pressures to increase procedural volumes and the attendant potential for unindicated surgery and testing. A commitment to quality and value-based payment programs plus maintenance of clinical control by surgeons can mitigate such potential problems. A private equity firm that is dedicated to collecting outcomes data and benchmarking results would be a superior partner. One that is committed to returning more clinical and financial control to surgeons through bundled payment plans, outpatient spine and total joint replacement in physician-owned ASCs, and other risk-sharing arrangements has the potential to add great value with increased quality.

There is no perfect practice paradigm; even private practice has its challenges of the current medical marketplace. As in surgery, understanding the risks and potential benefits are key to an informed decision.

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