In The Trenches_ Conversation with Scott Becker

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SPEAKERS

Scott Becker, Steve Divitkos

S **Steve Divitkos** 00:01

Scott, welcome to the show.

S **Scott Becker** 00:06

Steven, great to be with you. Thank you for having me.

S **Steve Divitkos** 00:09

It is genuinely our pleasure. I am familiar with your story, but many listeners may not be, so maybe we can just begin by having you walk us through your career and some of the major stops along the way that have led you to what you're doing today.

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Scott Becker 00:24

Sure. So I've sort of straddled two major careers over the last 30 plus years. It feels like forever, but fantastic. So I was a lawyer originally, and when I started to try and grow a legal practice, I was in a healthcare group and trying to build a healthcare legal practice. It is part of that I started a very, very rudimentary newsletter in very small conference that back in the day, I was in my 20s, and that's a long time ago, noone would give you the time frames. That'll tell you how old I am, but back in the day, I started as what you would call today thought leadership. Then people didn't use the term thought leadership. After several years of this thought leadership effort of building a legal practice, I started to wake up to the idea that thought leadership effort, the conferences and newsletters I was doing in healthcare, could actually, in and of itself, be a business. At that point, this goes back 25, 30, years ago, I started to make a much more serious effort at building out what is now called Becker's healthcare, a media company in the idea was to be sort of the Wall Street Journal, the business side of healthcare for hospitals and health systems, surgery centers, orthopedics and spine and other areas. So over the course of the last 30 years, built a team, both at the law practice and built, with a great group of lawyers and partners, a great healthcare legal practice that today spends a lot of time in the private equity and health system world, in the investment world, in healthcare. And then similarly and side by side, built out as a completely separate business enterprise, a healthcare media company that became one of the leading, what you'd think of as a business to business media company in healthcare, where audiences are hospitals and health systems. Health IT, orthopedic and spine practices, surgery centers and whole lot more, but the largest, largest part of that healthcare media company is in the hospital Health System world, and it's been a fascinating, fascinating ride. We've, you know, the key to all of it is building out great teams and really going after niches and great customers. And we've had great, great fun with it. And then I know we'll talk today a lot, a lot about private equity investing in healthcare. And if you know some of the areas I'm very much still on top of some of which I'm not. But we'll do our best to give thoughts on a wide variety of investment areas. And by private equity and healthcare.

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Steve Divitkos 02:56

Fantastic. And given that your background, I guess bridges private investing and healthcare, I guess I'd like to start by walking through some considerations that are specifically unique to healthcare. And I guess where I want to start is the idea of rolling up primary care practices, so things like dental practices, OB GYN practices, orthodontial practices, etcetera. These have been popular rollup targets for private equity and other financial buyers over the past several years, in part because these industries are so fragmented. That said, just because an industry is fragmented doesn't necessarily mean that it ought to be consolidated. So I guess the question is like, to what extent do you think that these are investment theses that are worth pursuing, like, how do you think this big push by private equity ends once all is said and done?

S Scott Becker 03:49

Sure, so we divide it very much into several different concepts. The first concept is, does the practice area that you're going into have decent and good margins or not, and this is incredibly important, because the sort of core business of private equity, or at least the method of doing business, is to add on some debt, take away some of the income of the practice. What people often call in healthcare private equity deals, a scrape of income, and then hope that you could manage to bring some of that income back. But at the same time, you are weighing down the practices with some level of debt, and that just sort of part and parcel of how deals are done. We talk about it often in The Good, the Bad and the Ugly. In terms of good, people are rolling up practices we see often with high margins. They're not doing too big an income scrape, and they're not over leveraging it. They're not putting too much debt on it. That would be sort of good or worse. Bad is, we've seen this recently with OB GYN practice was just one of the ones that you mentioned, is the margins aren't so strong so. You add on a lot of debt, and then suddenly you've got a practice that's almost upside down in terms of margins and physician compensation and what they could do going forward. So that's sort of the bad. The ugly would be when somebody so over leverages a healthcare asset that it causes the healthcare asset to go broke. And we saw that not long ago with one of the health systems steward healthcare that was, you know, financed through a private equity deal, private equity recaps and so forth. And just basically killed the cow, killed the health system business. But a lot of what happens is, when you look at these issues, you mentioned fragmentation, fragmentation from an investor's perspective, is a looks great because it means there's lots of runway to grow and do bolt on acquisitions and grow the platform. So if you think about it, you think about there's 200,000 dentists in the country or more. That is a very ripe Erie, and he has been for a very long time for consolidation, because there's still lots of independent dentist you could still organically grow a platform and do bolt ons to grow a platform, and do other things to grow a platform. So it's been a very attractive area. The next piece that is, and you'll just shut me up whenever you want me to Steven, is that fragmentation isn't everything, because you've got to have fragmentation with good margins. So if you look at dental specialty areas, like the implant business, the orthodontal business, some of these other areas, there's not quite as many physicians, but they're still very fragmented. And they have better margins, so they're better able to withstand some of the fragility of some of the debt add ons and the debt recaps and so forth. So pure dentistry works fine, but you can't over leverage it, because the margins are often small, and it depends what state you're in, whether you're working with a rich Medicaid program a poor Medicaid program, and under that sounds ironic, but some Medicaid programs pay very well. Some pay very poorly. Orthodontics, implants, some other areas end up being more ripe for roll ups. They're not they're still fragmented. There's not nearly the critical mass of physicians in them, but the margins withstand the roll up better. You mentioned another specialty in some of the notes GI practices, these have been a very ripe area for GI roll ups. There's been a ton of gastroenterology roll ups, and a lot of it has to do with good margins, good ancillaries, and then again, being careful not to over extend them or over leverage them, because then you end up putting so much pressure on the practice and the margins, and we'll talk about that more, but that maybe is a good starting point to push back to you.

Steve Divitkos 07:50

Yeah, and in your experience like, what differentiates successful versus less successful roll ups? You talked about margins, you talked about leverage, and specifically the risk of over leverage, over leveraging the transaction. I should say, is there anything in like the post, close operational playbook, so to speak, that differentiates the successful roll ups from the less successful ones?

Scott Becker 08:12

Yeah, I would think there's a couple different things. The place where we've seen good roll ups, there's two or three different things. Sometimes there's great roll ups where there's literally terrific smart physician leadership that really has a drive and an effort behind this. And look at HopCo, which is one of the orthopedic roll ups driven by today, Dr Barsoom and some other people. You combine it with SMART Capital, smart leadership, and they've got as good a chance of being successful as others do, if not more successful. The flip side is we see roll ups where it's really a financial play. Nobody's really thought that much about leadership going forward, and it doesn't have to be physician leadership. We've had great non physician leadership who just does a wonderful job of running physician practice, working with physician practice, you know, really smart people, but doesn't have to be the alpha in the room at all time. But actually, it's competent, competent leadership. I mean, the reality is, there's a beauty of a business that has 10 elite people in it. There's a downside to that as well, 10 elite people in it. You can't afford the leadership, you can't afford the scale, you can't afford the technology, you can't afford a lot of things that you can have in a larger business. You get into larger business, if run right, you could afford better leadership, better management, somebody paying attention to a lot of things so that things can really run well and be creative and strategic. Great private equity funds are very good at bringing in and supplementing the right leadership and at the same time not throwing. It's not like they're throwing, you know the old phrase of spaghettiagainst the wall and seeing if it sticks. They're really, really disciplined about trying to build things in a systematic, smart way. And they're smart, smart operators, not just smart financial engineers. So I think those are differences.

Steve Divitkos 10:12

You talked about this idea of physician versus non physician leadership, which I definitely want to get to. But before I get to that, I want to ask about where you think we are in the investment cycle, so to speak. And by that I mean like, let's take the DSO or the dental roll up strategy as an example, just because it's a very common one. I guess my question to you is like, is this still an investment thesis that you think is worth pursuing, or has the train left the station, in a proverbial sense? And the reason why I ask this is because this has been an investment thesis, rather common one, for many, many years. Now, there's a lot of buyers in the space. There's a lot of capital. I would imagine that multiples have expanded. I would imagine that dentists now know with reasonable accuracy what their practices are worth. Like, has the train left the station or is this still a thesis worth pursuing, in your opinion?

Scott Becker 10:58

You know, I look at it one bit differently. I look at it as, is the dental business ultimately a decent business or not? And so if the dental business is ultimately a decent business or not, it could still have room for roll ups, for acquisitions, for DSOs, for growth. I mean, it's certainly a mature industry. You're not doing the first 10,000 dentists out of 200,000 and doing something that's going to get sky high multiples, but you're also in a decent business area where there's still plenty of pockets where the margins are solid, there's an ability to recruit dentist. There's not such an incredible shortage. You could still do it. I look at in contrast, people trying to roll up OB GYN practices. And again, it's top of mind, because I've seen some disasters recently. There's just not enough OB GYNs. There's not enough margins. And so no matter how you play it, it's a very hard business to roll up and the OB GYN roll ups were more recent. There were some a long time ago. There's some more recent, but a very hard business to roll up and make work well. You see your racial roll ups, GI roll ups. There's been a lot of this going on for a long time, but the beauty of it is and there's some more shortages coming in those areas, particularly in GI but the beauty of it is, is they've been relatively good businesses with good margins, with good answers, with good opportunities to make money. So even though they've been rolled up ad nauseum, there still seems to be opportunity in them. It might not be opportunity with crazy multiples. So I sort of look at it, you know, every area, everybody's trying to look at a roll up strategy from time to time. Currently, the Bloom is a little bit off the rose in terms of physician roll ups. There's not nearly the interest in physician roll ups that there was five years ago or 10 years ago in general. But in terms of where you're seeing it falling out. You know, back in the 90s, there were a ton of public companies that were rolled up, that were physician practice management companies. And the history of it is, I think almost every single one of those ultimately went bankrupt back in the 80s, 90s, whenever it was, it was a long time ago. This most recent run of roll ups over the last 10 years, everybody thought this was going to be different. And what we've certainly seen over the last 10 years, lots of trouble with lots of roll ups. And the roll ups that are doing well are ones where the businesses, the core business, is fundamentally sound. So there's been lots of trouble in, for a long time. So much of the energy was around hospital based specialties, emergency room, oh my goodness, radiology and some other areas, anesthesiology and so many of these roll ups were so hot for some period of time, but then crashed as they had trouble with hospital margins, hospital relationships, payer relationships, everything else. It's a lot of it goes to, is the business fundamentally sound or really challenged or not?

Steve Divitkos 14:17

Can you talk to us about the idea of a non physician buying a physician centric business like the one that we've just described. And the reason why I ask this is because, you know, in my world where I support entrepreneurs looking to buy a business and then run that business going forward, if you are a widget maker and the founding CEO leaves, well, presumably that you can step in as the CEO of that widget, making company. However, if the founding physician leaves in a primary care practice setting, you cannot, as a inexperienced operator, step into his or her shoes. And that always struck me as, I mean, a very obvious risk, but a risk nonetheless. So can you just talk about this idea of a non physician body owning such a physician centric business?

S Scott Becker 15:03

Sure. I mean, there's multiple different pieces to it. One, there's obviously a legal and regulatory piece where, in many states, non physicians aren't allowed to own a physician business or professional services business, just like in many states in the United States in general, and mostly non lawyers aren't allowed to loan legal practices. And it's more recently that different types of events have been able to own accounting practices and so forth. So you end up with this core issue of the legal issues, and people work through MSO structures and other types of things to try and reflect kind of ownership dynamics, but not true ownership. And there's all kinds of complications and discussions with that that we won't go into into that much depth. So the next question becomes the business side of a non physician owning a physician practice. And this is again, it goes back to something if you're a physician, if you're a physician practice with three to five physicians and a non physician buys it. That non physician obviously can't step in to work in one of the spots that those physicians worked in. Obviously, that can't happen because the person's not qualified to do so. So you can't be a sort of investor doer, investor manager. You could be an investor manager, but you can't be an investor practitioner. So that's one piece of it. So that leads you to the next step. Is one of the great orthopedic business minds I worked with over the years who ultimately ended up working with Optum, is a spine physician named Dan Murray. And Dr Murray used to say this about practices is that until a practice had 20 physicians, it wasn't a real business. And his mindset was that up to 20, you could always have two to three, hold yourself, hold your business hostage, and sort of say we're running for the gates. We can't stand management. You know, that there were a bunch of things that any one or two could do, especially those with disproportionate earnings, disproportionate revenues, if they want to be difficult. And many of us in the course of our careers, have seen that time and time again. You know, we saw a doctor in one practice almost blow up the practice because he was a leader, but hated the practice move guys out, and you see this time and time again. So if you're a non physician investor or a non physician leader, it's much like you talk about the search fund model versus the private equity model versus the VC model, but you get into, from a private equity standpoint, it just goes to fragility of a practice. You can't buy too fragile practice because you know you can't step in as an independent sponsor or search fund investor or private and practice yourself. I mean, you have to be buying into a stable enough practice. And know, the people know the physicians, know the situation. So you're not so reliant on any one or two physicians and so forth. I sort of look at it that way from a regulatory sort of standpoint, and then from a business standpoint. I wouldn't want to be running something where I'm reliant on one physician, two physicians who could get hit by a truck and were in trouble, or have a bad day and have a fall with management and you're in trouble.

S Steve Divitkos 18:32

Yeah, I'm curious. You mentioned a colleague of yours who mentioned something to the effect of, if you don't have more than 20 physicians, you're not a real practice. Curious, do you agree with that sentiment?

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Scott Becker 18:43

I think the point was directional versus absolutely the key, the concept, I mean, you could have a practice of four people in a town and be a very important practice. It's very hard to be a practice of one today, although people do it because you end up having to support a lot of administrative help, and you don't have people to help you with call. You don't have people to help you with backup and support. It's just a prescription for burnout. I see people do it. It's just hard to sustain after a certain age, after a certain time, and so forth and so on. His point on the 20 was not that you don't have a real practice, but that you're still too prone to being held hostage by any one physician who gets sideways with management or hates the group. I mean, there are great orthopedic groups, great GI groups, great ophthalmology groups that have three to 10 physicians, no question. And they're very much real groups. The issue is, as an investor or as a CEO leader, I remember originally building a legal practice back in the day and having one lawyer work for me. And when that one lawyer quit, I was starting all over again. And it became very clear, had to build enough, big enough business to build a big enough team so you weren't as fragile. I think Dan's point was, he did a big enough team, a big enough group, that you could start to hold people accountable, that you could start to have people he have clarity about what they're supposed to do, without having anybody in any day say, I screw you, I'm leaving. You know more that. But I think he would say, and I would say, there's plenty of great groups with a smaller number of physicians than 20, but that was the point at which he felt like one super producing physician couldn't hold the rest of the group hostage.

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Steve Divitkos 20:29

Yeah, yeah. And that's actually a risk that we're going to get to in a couple of minutes. But before we get there, I want to talk about two of the most common structures that I see. And I don't know if this is representative necessarily, but MSOs, managed service organizations, and DSOs, dental service organizations. You know, in my experience, they often try to sell physicians on the merits of operating within those structures, basically by saying, Hey, you focus. You focus on practicing medicine while we focus on, like the administrivia of running the business, taxes, payroll, insurance, recruiting, etcetera. My favorite questions benefit from hindsight, and that's kind of where I want to go with this one. With the benefit of hindsight, because this is not a new pitch to physicians anymore. Has this value proposition actually proven to be true historically? More specifically, like, do physicians and dentists look back on their decisions to join an MSO with fondness or with regret in your experience?

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Scott Becker 21:23

Yeah, I think it's a real, real mixed bag out there. I think what happens is different operators, different investors, different MSOs are still better or worse at it than others, and so you have MSOs just like you have private equity funds who have built really clear plans on how they do business, and they actually do business in a decent way, you've got a huge continuum out there. So I would say that sort of, oh my goodness, the overall font or not bond. I would say that I would put that at, you know, maybe 30 40% fond, please. They did it 67% not so thrilled, not so fun. They did it somewhere in there. And that's a very vast, vast number, and it's depend over the course of time in vintages too. You know, if you sold your practice into one of these things over the last five to 10 years, you might have done so with the hope at the second bite of the apple that you'd actually make some capital on the back end too. That has, of course, become less and less common the last five to seven years, as the cost of finance or debt has stayed high, the exit environment has stayed weak. So many people that hope for a second bite of the apple haven't seen that. A lot of it depends on how big this income scrape is. Any physician who sells part of their income upfront in exchange for a capital payment is happy on day one, and it's almost like a graph that happiness goes down every single day, that they're making less income than they were, even though they sort of remember that they got to pay out at one point. And then you get into this management issue, management, professional late management, is just all over the board, you know, in terms of whether that's quality management or not quality management. I mean, the concept, obviously, so many management companies have sold a bill of goods that we could do this, we could do that. We could do this. We could help you with this. We could help you with that. And so much of healthcare stayed relatively local, you know, so it's the idea that a private equity fund could help you greatly, or private equity sponsored MSO, or DSO can help you greatly with payers is often overstated, so people don't see that benefit. You know, sometimes you do have plenty of groups, 10, 20, 30, 50, physicians, whatever the number is that could use professional management and have struggled for a very long time hiring a chief administrator or chief leader to run the group. Sometimes the right private equity investor, the right MSO, the right DSO just is going to do that better. But often you've had, at least from a generation of physicians, a lot of physicians that really did a pretty good job of running the group and knew their business really well. Now you do have this, this, this situation going forward, where you've got a whole mix of physicians attitudes on wanting to actually run a business today. So so I'd say overall, I wouldn't say I get a percentage of physicians that are actually thrilled they did it and fond of it and pleased with it. Generally, they're in practices that are going well. The strategy has gone well. They've got great leadership, physician and lay leadership, and then you've got a lot of practice, I would say that are not happy with it. Often, it goes back to that we talked about earlier during lower margin businesses. They've recapped heavy they've ended up squeezing the practice, the growth's not going as they wanted it to grow. You know, a lot of that.

S Steve Divitkos 25:06

Yeah. One of the things that I've seen in the healthcare opportunities that I've looked at is this idea of physician incentives post close, particularly if there's a super producer within the group of physicians, which is often the case in small practices. So have you seen in your experience any particularly effective ways where buyers structure physician incentives to ensure alignment with them after the acquisition is consummated?

S Scott Becker 25:34

No, I think that's a great question, and I don't know that there's an easy answer to it. We're a huge fan of is we see certain buyers, and you see this in the PE space generally, that you have a tremendously well compensated CEO or leader, and the private equity fund says, we just don't compensate people like that, and they want to change that. And you also see situations in private practice where, you know, often people have productivity based compensation, and that worked really well for high producers that are very much, you know, they like the money, they like the dopamine fix. They like to be recognized for what they're doing, and this is how they've ran their practice for a long time. So what I see is where I see challenges is where a private equity fund or a sponsor or a management services organization feels compelled to make big changes to comp when that comp has been working for that group for a long time. And it's a complicated issue, because you get into bigger and bigger groups, there's always this desire by central management to standardize things more, to make them more a certain model. They often want to make more of the income and the revenues, group income and group revenues. And often they end up screwing up because they've missed what's driven a lot of a lot of the success to begin with. So we're huge fans of trying to figure that out. There's a lot of big roll ups in the orthopedic world, where they've kept business unit accounting within reason as much as they're allowed to where the business unit still is a business unit. It still relatively runs like they were a business unit. And that, you know, a lot of the Confederations I've seen of groups work really well like that. It's where I see challenges sometimes is you get central management that views it as and there's a fine line that we need to centralize everything. And what happens is, it makes incredible sense to the CEO or the leadership or people that are counting money and saying, we'll have this as an asset for the group versus for the physicians. But it's, you know, sometimes we see that backfire, because so much of the motivation, it's not just the money, it's the I'm earning it, I'm doing it. This is what I do. This has worked for a long time. Every time you change comp models, you have a bit of wealth in practices, you have a bit of a resentment in practices. And so I think it's a fine line as to how you work with maintaining comp going forward, and how you deal with it.

S Steve Divitkos 28:26

And with respect to physician incentives and comp, are there any like recurring mistakes that you see? So for example, when it doesn't go well, are there any through lines? Is it the simple fact that comp is now different that is the problem? Is it the buyer over engineers it and makes the comp formula too complex? Is it non physicians don't know what metrics around which to base comp? Is there any kind of recurring theme that you see when these post close incentives don't go particularly well?

S Scott Becker 28:59

I don't know if there's a specific theme that the if I had one theme, it's change that's not necessary to be made. You know that sort of you would go to your over engineering point. Obviously, complexity is the bane of all comp. I mean in every situation, in the old days, payers with physicians would try and add on withholds and other ways doing comp. And sooner or later, the physicians would view it as I'm just not getting that comp. So I'm going to view my real pay as whatever I'm paid, regardless of withholds, regardless of bonuses, regardless of anything else. And so I don't know how to I don't know if I have a specific answer to it, but it's like anything else in business, like you've done a brilliant job of explaining to me earlier on what a search fund does and what you do and how you've done it, and I'm a huge fan similar with compensation. If you can't explain it to somebody like they're a fifth grader so they understand it, you sort of have made it bad.

S Steve Divitkos 30:00

Yeah. So sticking on this theme of like risks specific to these types of investment, theses, anytime I've looked at like a primary care deal, three risks in some way, shape or form, seem to present themselves. So the first is payer risk, Medicare, Medicaid, maybe concentration, with like a one or more commercial payers. Second is physician concentration risk, which is what we've talked about, like a super producer that accounts for an outsized share of total Billings. And C is something that I'll just like loosely refer to as clinical risk. So for example, are weight loss clinics still going to be as relevant five years from now, given the rise of GLP1s? So those are, like, the three risks that I see over and over again. Maybe a two part question. A, do you agree or disagree with that? And B, are there any other primary sources of risk outside of those three that you tend to see over and over again?

S Scott Becker 30:54

Yeah, no, I think you've nailed it. I mean, the physician concentration risk really goes back to the question we talked about earlier with the 20 physician issue, you know, it's, do you have anybody that's so important that if they leave we're in trouble, or so important that if they have, if they want to shoot the CEO, we got trouble, or they want to leave the group, whatever it is. So I think the physician concentration group, are you too reliant on one or two people, versus versus the whole group? Clearly, is a big, big risk in physician to yields the payer risk and understanding what your payer risk, what your concentration is. You know, in the old days, people used to buy practices that were very reliant on workers comp, out of network or a specific type of payer. And is that changed, you had to make sure that the practice was still very sustainable, with or without those you know, payment streams, clinical risk is a fascinating issue. I mean, bariatric surgery in this country is recently gone down 30% over the last couple of years with the advent of GLP1s and so forth. And that's not exactly where you're going with it, but it's a really good example that. Similarly, the Jenny Craig's of the world, like there was a weight loss guy that I went to for regular weigh-is and stuff like that, and just to keep track of and keep myself disciplined, and his business, they closed down their business. Just as an example of changes in things, back in the day, and there was this growth of what were called Heart hospitals. And I not, I mean supposed to heart hospitals, and those were reliant on cardio bypass surgery. And the the companies that were in the medcast business, the cardiac hospital business, cardiology hospital business, just basically got blown out of existence when stents became the way that you primarily treated heart disease. So you see a lot of these different changes over the years that are clinical risk. The flip side is, I served on the board of a GI company 25 years ago and for a very long time, and worked with their leadership for a very, very long time, they ultimately sold for an insane amount of money to one of the big the big insurers in that space were hyper successful. But if I went back 25 years ago, or 30 years when I first worked with them, we were very concerned then, that colonoscopies would go out of existence, that it would be done in a different way, that it would be done through, you know, through a pill, or through a camera, through a number of different blood tests and so forth. 30 years later, every gastroenterologist in the country still has arthritis from doing so many scopes, from doing so many things. So we look at clinical risk and changes in the clinical environment it but I'm often reminded that the next new thing that's going to kill something often comes much, much, much slower than expected, and there's huge built in constituencies and advocacies around certain things that that that makes that a slow change often. I mean, the cardiac hospital thing, was fasinating. A ton of cardiac hospitals were built. It was going really well, and then that fell apart quickly. I mean, over a course of a couple years, that became a disaster where you couldn't support cardiac hospitals alone, because the world had moved to stents versus cardiac bypass surgery. The bariatric thing is fascinating right now, just to see how quickly bariatrics have slowed in response to GLP1s. I mean, you do see those things. Urology is one of the most interesting specialties because over the course of the years, they've gone through different ancillaries that were the drivers of the profits. At one time, it was a drug called Lupron, wherever urology practice for a few years, this was where they were making all their money. Then that got basically eradicated. There's a [inaudible] center, they went back to withtropsy, to surgery centers to radiation, radiation therapy centers and so forth. But the changes, and I think the lesson is. Is you have to be in a practice area that's got good enough margins that can withstand these changes and that you could find the next spot, the next revenue place. You know, well, things change and well things evolve.

S Steve Divitkos 35:11

So specific to this clinical risk, right? You gave a couple example. You gave the cardiac example where stents and the advent of stents, and the growth of stents significantly changed that business. You know, I'm mindful of like, a GI practice today that has 40% of revenue coming from, like, weight loss treatment. What is that going to look like in five years? You mentioned you were on the board of a company, and you were questioning, hey, are colonoscopy is still going to be a thing five to 10 years from now? So I guess in each such an example my question is, how does one diligence that type of clinical risk, especially as like a non medical professional? Or is it even possible to diligence that type of clinical risk?

S Scott Becker 35:52

Yeah, it's a great question. I think probably diligence. I mean, it's not really the GI practices making money from weight loss. It's different primary care, it's different businesses. It's a million different places when the GI practice is still making money through colonoscopies and Gastroenterology and so forth and so on. But that's not really the point. The point is, how do you diligence it? And I think you just have to, you know, I don't know if ever great answer to that, but you see, for example, waves, where big primary care practices got really wealthy for a short period of time, when Medicare Advantage exploded during COVID, and then the margins came way back down. And you have to sort of understand what you're buying into, why you're buying into it and what the longer term looks like, and have to be able to try and understand it. I don't know if there's an easy answer, but the lesson that I've seen over the years is so many businesses hit an outsource piece of their business drove the profitability of it, and then you have to look at that outsource piece of the business that drives the profitability of it, and make an assessment as to how risky that is. You know, in surgery centers, there's a surgery center chain that was doing incredibly well without a network business, meaning that they didn't sign concerts to the insurers. They bill the insurers directly. And, you know, many, many buyers steered away from it and wouldn't buy it, or they'd buy it at a lower multiple because they were scared of that out of network business, one of the big companies ultimately bought most of those centers, and it's done tremendously well with it for a long period of time. So you know, a lot of it has to do is you're a buyer of businesses. I've been an investor over the years. You know, sometimes, as an investor, this is a no brainer, and you know that this is a winning situation. Many, many other times you don't know, and when you don't know, you're usually in trouble. You know you're just, you're just not as knowledgeable as somebody who really understands it. It almost goes to your point on not being a physician. You know, if you're a physician buying a small primary care practice, well, you could roll up your sleeves and fix it. If you're a lay person, entrepreneur, you feel little bit powerless because you can't roll up your sleeves and fix it. You better find a way to recruit other practitioners. And you don't know the business like you did. You know it? You know it's periods of times in your life as an investor, you did it really successfully. I've had times where I've been really successful as an investor, times where I've not been successful as an investor. And generally, when I really know something, it's obvious, and when I don't, it's much more challenging to diligence and figure it out. Yeah, yeah. I think the answer is that there is no easy answer to diligence this type of clinical risk. Let's talk about payer risk, though, because that's something that we've talked about a little bit, and I've always thought about this, rightly or wrongly, you tell me, as a sort of like inevitability, almost like a cost of doing business when investing in certain sectors of healthcare. So at a high level, like, how should buyers think about payer risk and more specifically, like, under what circumstances might pay a risk be palatable or acceptable, and under what circumstances should payer risk be seen as a deal killer? Sure. So payer risk has changed a lot over the last couple decades. I mean, back in the day, one of the great leaders of in healthcare was this guy, John Rex Waller, who was a Rhodes Scholar and then built a company called National surgical hospitals, was hyper successful. I'll get to a point on this, I promise, Stephen, but, but he, but John, used to describe a perfect market for them to be in is one there where there were five or six payers and no payer was dominant, no payer had more than 20% of the market or so. And in the world over the last 20 years, changed dramatically. So every market that you go into, and almost any state that you're in, well, if one dominant payer, one dominant commercial payer. Or typically a Blue Cross or united and Aetna, Cigna, depending what state you're in, it'll have a secondary payer, but that one payor that's dominant is critical. Can you do business with that payer or not? And then what's also happened over the years is, back in the day, people made a disproportionate amount of their money from that, those commercial payers that would pay two to three to two to five times what Medicare or Medicaid paid. The world has changed so much over the last 20 years. Now in most businesses, you're in Medicare and Medicaid are going to be an important part of your payment base. So if you're an ophthalmology, Medicare is probably 80% if you're in the cataract business, we're in the GI business. Medicare and governmental is probably 30 to 50%. So you have a different kind of payer risk than you had some time ago. The bigger payer risk on the Medicare Medicaid side is not so much the regular reimbursement. It's that the movement of seniors to Medicare Advantage Plans throws a whole nother wrinkle into what payer risk looks like on the Medicare Medicaid side. Because you used to be able to, as an investor, as an operator, look at the Medicare and Medicaid side and say, it's stable. It's not great for hospitals, it's okay. It's not going up, but we basically know what we're dealing with. Now that's changed as the government has pushed a lot of that down to Medicare Advantage plans, which are just like being again, in business with all the commercial payers. The commercial payer standpoint you really look at, you're buying into a business, or you're investing in a business. What are the relationships look like with the top two to three payers that they have? You know, what do those look like? Have they been long term relationships? Do they look challenging? There's a reason to view those as fragile or not, and you just go back and forth over time with how difficult those payers are in terms of reimbursement, pre authorization, denials, all those things. I don't know that there's any easy answer on it. Payer risk is going to be critical every place the payer risk that's not acceptable could come in two or three different ways. One is, you've got to practice your business you're investing in, that skirting or fighting against payer rules to stay in business, or they're making disproportionate profits because they're doing something the payer doesn't like. That's a challenge. The second thing that happens is, we've seen this often in healthcare, and it's not so much that you stay away from it, but you have to price it. And it's very hard to make a price deal on this with with your seller is you've got a place where a practice is making disproportionate parts of their income. And again, it goes back to things we were talking about earlier. It used to be in California, workers comp. In some states, it still is workers comp. You've got a very generous Medicaid program in some states. You don't expect that's going to stay. You've got out a network where people are making a disproportionate amount of their income, or you got a payer that's still paying you a disproportionate amount. I mean, you know that compared to what other people are paying you, you don't know whether that will stick or not. The other thing that's happened is, which is a good thing for physician practices, you know, they're back to the world of more cash pay, more dollars coming in direct from patients, and trying to figure out that business and whether it's whether it's a real hedge against some of the payer risk or just a headache. And it could be one of either.

S Steve Divitkos 43:26

Yeah, how about recruitment and retention of clinical staff? So doctors, nurses, therapists, etc. I mean, that is a challenge that I've seen in basically every healthcare deal I've ever made or considered. So I guess the question is, like, Is this a new challenge, or has it always been this way? If I were to have written an investment memo 10 years ago, what I still have highlighted recruitment and retention of staff as, like, one of the top three risks in the deals and like, you know what if anything is different now than I don't know, five or 10 years ago?

S Scott Becker 44:02

Yeah, no, I think this is a much, much, much, much higher risk than it was 10, 15, years ago, for a million different reasons. I mean, the first thing is, you know, look at this from multiple different perspectives. The sheer number of physicians in the country, 900,000 practicing physicians, 1,000,001 physicians, compared to 340 million people. It means if you're trying to organically grow a practice or add on to a practice, there's just not enough doctors to add on to that. If that's part of your growth thesis is adding on more doctors, adding on more physicians, it's just very, very hard to do. And so it's a real risk. It's a much worse risk than it was 10 years ago. 10, 15, 20 years ago, there wasn't so much competition for the physicians, and there was a better percentage of them compared to our population. So it's a much worse risk now than it was 10, 15 years ago. I spent a lot of my time early in my career in the surgery center business with people. Building out, buying, growing surgery centers. In the old days, you could build a surgery center know that you had half the cases accounted for and recruit to fill out the others. Today, you would never build a surgery center without knowing you've got almost 100% of your cases that you need to be in business accounted for, because there's not free physicians around to add on. There's just not independent physicians to add on to that surgery center. But that same thesis or challenge is the same in practices across the board, there's just not enough to add on independent and it's different specialty by specialty, of course, but in most areas, the competition for physicians is fierce. There's not enough of them. More and more physicians go part time by 40 more and more want to have a job at a hospital health system, versus being in an independent practice some sort. So just the number of physicians, it is a daunting problem. Clinicians and nurse staff. One of these that's happened in our country is we have greatly expedited education for nurses over the last few years. So we are now producing 175,000 to 200,000 nurses a year. We produce, to give you a contrast, we produce about 25,000 physicians a year. So what Tampa did is, for a couple of years, during COVID, the nursing situation was impossible to fill. That is getting better because nursing education has been expedited. The education has been expedited. Physician education remains in sort of the, you know, the Dark Ages, in terms of how we do it. And there's lots of discussion behind that. We can get into it, not get into it. It's probably beyond the discussion here. But physician education hasn't changed in 3050, years. Nurse Education, they accelerated. So we're producing nurses again at a pace that's pretty good. Physicians were producing at a pace that just doesn't work. And more and more go part time by 40 our education system produces great physicians, but it's asked backwards terms of the length it takes, the debt it takes, everything else just it's not been improved in a very long time, and it's a disservice to all of us.

S Steve Divitkos 47:09

Yeah, is there anything unique to the recruitment and retention of clinicians that maybe is not true when speaking of recruitment and retention generally. So by that, I mean, you know, why does any talented, ambitious person stay with any organization? Probably, a combination of transparency, culture, values, mission. Do I feel like I'm making a difference? Am I being used in the way that I ought to be used? Etcetera Presumably, cetera. Presumably those are applicable in with respect to doctors and nurses. Is there anything specific to doctors and nurses that is particularly important, Vis a Vis recruitment and retention, that is maybe unique to them, that isn't true in other industries?

S Scott Becker 47:58

Yeah, it's a great question. I don't know the answer to that. I know that what's happened is you're really, you're immediately limited, because you're dealing with a licensed professional field. So you're immediately limited in the pool you can go after, because you go look after licensed people, you know. So for one business, we're in the process hiring a bunch of salespeople, you know, your pool is very large. It doesn't mean you want to hire everybody. Your pool is very large. In the nursing sector, you're immediately limited to 5 million people that are licensed nurses. And then you've got another challenge, of you've got an increasing number of nurses that just don't want to work in an inpatient setting. So now you're limited, and you're limited, you're limited, but if you're outpatient, and you have flexibility, you're not as limited. But then you get to the same things as anything. Are you paying people fairly? Do you have a good culture? Are people pleased with where they're working? Do they like the people they work with? Are you developing a good culture? Are you not? Are you a professionally run culture? Are you not? Are you giving people the flexibility they want? Are people doing good work where they can be proud of the work they're doing, or they just punch in a clock. You know, once you get passed back to licensed or not licensed, I think you get back to a lot of the original issues of, is it a setting? Is it a culture? Is it a compensation?

S Steve Divitkos 49:11

Yeah. These are more like human level considerations as opposed to, like Doctor specific considerations it seems like.

S Scott Becker 49:18

I think largely, and I think half the doctors coming out are going to go part time by the time they're 40 or so. So you have to, you know, just like you have to do in other workplaces. Evolve workplaces so that people have flexibility, so that they could work shifts or plug in, you know. And it's complicated in growing a business and growing a practice.

S

Steve Divitkos 49:41

Yeah, before we get to our concluding question, I do want to ask you two questions about the rise of AI, specifically in healthcare context, because I find the intersection of AI and healthcare to be just utterly fascinating, and arguably is going to be one of the most beneficial use cases of AI at like, a societal level. So I guess if I were to put on my AI optimist hat, I would say that many healthcare settings either will be or at least could be, totally redefined by AI within as little as the next, like two to five years. And just as a little anecdote, like the pictures of GPS double checking their diagnosis with ChatGPT, those have already, like made the rounds on social media. So I guess the question to you is, how has the rise of AI colored your view of healthcare investing? If it has colored it at all?

S Scott Becker 50:29

Yeah, no, I think you're going to see this huge transformation. A place where I see it the most clearly is in the primary care field, because I think it's basically upon us. And I'll give a quick anecdote. I've got a great primary care physician. I've had him for 30 years. He's a close friend. Love the person. Went to college when he grew up near me. Great primary care physician. I went to reschedule my appointment for next week or this week. The next opening is April, 2026 and again and again. I can get in because he's a close friend and can work the system, but that itself is an indication of where we're going, and I'll take you back to the stats I shared with you a second ago. We're producing 25,000 physicians a year, of which maybe 8000 is primary care. We're producing 2000 nurses a year. And so there's no way around the fact that we're moving to a spot where a huge, huge percentage of primary care is going to be done by pas and nurse practitioners and so forth. It just that's where we're going, whether you like it or not, whether we think it's best or not. You know, we all prefer, or did prefer, at some point, the highly educated doctor who sat with us and talked through with us everything. Maybe we all preferred that. It just, we're just moving away from that. There's just no way around it. When you go to the dental, the dentist, the hygienist, sees you for the entire appointment. The dentist peeks in for two minutes, half the time to make sure that things are going right, half the time, it seems, so they could check the box that they could bill for it. Who knows? I don't know. But in primary care, there's just no way that we're not moving towards that. I mean, just there's no way around it. With the shortages, we're producing 8000 primary care physicians of the year, or something like that, versus three, 40 million population. There's no way around that. Now the flip side is, we better produce enough specialists, enough neurologists, enough brain surgeons, enough everything. Because I don't know that AI has taken over that that quickly, you know. So I don't know how quickly it's taken over some of those things, but in primary care, by necessity, you're going to have, hopefully, well trained, well educated, smart PAs and PEs with good tools providing great primary care is, I just don't say, I mean, people say that we're short 200,000 primary care physicians today. We only produce 8000 a year. We're just not getting there ever. I mean, that ship is almost sailed, I think. And that's not a discussion we had 10 years ago or five years ago. But at this point, have come to the conclusion that ship has basically sailed, and so we better figure out a way to do primary care with nurses, PAs and AI. And the optimism to that would be if we have 25,000 residency spots a year, and we need more. You know, it's a very, very politically charged discussion, because a huge amount of population thinks all those spots should be used for primary care. My belief is that that war has been lost, and so we ought to use more and more of those spots for specialists and make sure at least we have the specialists we need to back up the nurses, the PAs, the AI and everything else that we have so, but these are slow changing in medicine, so we end up with, we've ended up in the spot where nurses and pas are going to provide our primary care, not by original choice, but sort of necessity being the mother of invention. That's where we're going.

S Steve Divitkos 53:51

Yeah. Are there any like, specific use cases for AI and healthcare that feel particularly real and investable to you? And I guess conversely, are there any use cases for AI and healthcare that seem more hype than substance to you?

Scott Becker 54:06

It is a great question. I mean, we're already seeing places where AI is having a real, real impact in Receivables Management and revenue cycle and administrative tasks and lots of things. And we've obviously seen in other industries, where so much of the call center stuff has been taken over by voices that aren't human voices. But hopefully at some point you've got to default to human voice, when you just get fed up and get it zero. You know, I don't know what is challenging is there are so many AI companies and so many AI solutions that, you know, you're trying to see which ones stick and which ones don't. And I think a lot of it comes down to really two or three things, do people actually like working with it? Can they show that quickly? And then can they commit to constant improvement? And can they commit to great distribution? You know, you could have a great AI solution that you or I like, but if we don't have distribution, and they can't keep on improving it, it's irrelevant.

Steve Divitkos 55:19

Yeah, as we look to land the plane here, Scott, I'm curious what sectors of the healthcare market most excite you as an investor today?

Scott Becker 55:31

Yeah, no, I look at it a lot based on, you know, margins and opportunities. And it's very hard to invest in areas where the margins are not good, because, particularly if you're laying on debt on top of that, you're doing other things with it. They just don't work. So I don't know if I'd look at it by specific specialty. I look at it as though, is there a pathway to growth? Are there margins? Is there some lack of fragility to where you feel reasonably safe, I don't know that I got specific areas that I look at and say, Oh, my God, that's a winning area. But just in the day to day discussion with groups, with private equity funds, with watching colleagues and what's happened with them, you know it? You know, we look at it as the things that have had decent margins have been able to sustain themselves through the ups and downs, the fragility, adding on some debt, the things that don't have decent margins have been a disaster and, you know, and real challenges. And so I sort of start there.

Steve Divitkos 56:37

I wonder if you have any thoughts on the inverse of that question, which is any particular sectors of healthcare that frighten you most as an investor today? And to loop it back to the AI question, you know, radiology is often a discipline that's mentioned as one that is quite perilous right now, because the basic thinking is, instead of having a human being read the output of CT scan, or an MRI or an X-Ray, AI trained on every image ever produced over the past 100 years, will do a much better job than a human. So radiology is often mentioned as like a particularly perilous place to invest right now. Anything else come to mind when you think of like those areas?

S

Scott Becker 57:18

Here is the here is the converse to that, and here is the challenge to that Steve is with radiology. Radiology is one of the perfect examples of Radiology, by necessity, ended up using telehealth way before the rest of the world used telehealth because you just couldn't get radiologists out to remote in rural areas. Radiologists been talked about for five years as the place where AI would completely take over, because exactly what you said, every image has already been looked at. Everything's been ever talked to, stuff like that. The flip side is both, in the traditional radiology space, in the interventional radiology space, we are facing horrendous shortages, because somebody's still got to work with all that AI and somebody's got to still work with all those tools. So like one of my college roommates, one of my best friends, is an anesthesiologist. If I would have thought any area could be aied out of business, it would be his job. And I joke with him about this regularly, because a machine should be able to better titrate a computer, what anesthesia somebody needs versus not? Now, the reality what has happened, and the reality of all this stuff, it's you still need this mix of technology plus humans to do most things, and the more that you dumb down that human, the more risk you have when the patient has whatever complication they have. So there are pieces of it that could be done, but I'm always hesitant to make predictions until I could see it so clearly. I mean, I think primary care, we are just going that direction, and it's going to be PAs and nurse practitioners with AI. And if we PAs and nurse practitioners are smarter triage to what physician has got to get to. But I just think in so many of these specialties, where the prediction was that they would be all out of business 10 years ago, five years ago already, it just got happened. Like you look at this in like, friends of ours are in the wealth management business, and you would have thought of any area wealth management could be a died out of business. But the reality is, when the market goes down 20% when President Trump first announces tariffs and goes up 20%. Many, many, many, huge percentage of investors still want somebody to talk to and deal with, notwithstanding the fact that they might use AI behind them to research and study and figure things out and what the right outcome is, and all those kinds of things. So I don't know. I don't know. I think I'm a big fan of we better trust and verify, people that think that technology is the entire answer to healthcare. When I look at China and India during COVID, who believe that preventive care could fix everything, I've come to the conclusion that we better trust and verify which we better pursue all the technology we can we better pursue prevention, but to verify is we better have enough doctors and nurses on the back end, because if you don't have both, I think we're going to be in a lot of trouble. And I think it's very hard for me to hard for me to say, you know, I would have thought when I was told that we're short radiologists a little while ago, I was blown away, because exactly as you said, the ultimate use case for AI was why we could possibly need radiologists, and it turned out we do. And the same thing, particularly interventional, but radio, general radiologist too. And so I think we better trust but verify is keep on doubling down on technology, but we better double down on our physician labor force as well.

S Steve Divitkos 1:00:51

That is an optimistic note that strikes me as a good one to end on to refute the AI doom and gloom that I'm sure we've all been exposed to quite frequently. Scott, for people who are interested in learning more about the intersection of private investing and healthcare, your podcast strikes me as a very instructive place for one to go. So any final thoughts on where people can find you your podcast or any of the other content that you produce?

S Scott Becker 1:01:21

Sure. So the easiest place to find me is probably on LinkedIn at Scott Becker. Easy enough. I've got a couple of different LinkedIn accounts, but Scott Becker, find Scott Becker, you'll find me. Then people can always find Becker's healthcare online, which is the media company I founded, and still serve as Chief Content Officer on the board of still very, very involved in, and then I do a lot of stuff in the business and private equity space. It was started really doubling down on learning and media efforts in that space seven to 10 years ago. And there you can find me at www.Beckerprivateequityandbusiness.com. Becker private equity business. Steve, what a great pleasure to visit with you.

S Steve Divitkos 1:02:06

you. Oh, what a great pleasure to have you. It was so interesting to talk about these with you today. So thank you so much for joining us.

S Scott Becker 1:02:12

Thank you. Bye.