In an era where industry and private equity buyers are heavily pursuing acquisition opportunities in the dermatology market, practice owners are assessing ways they can best structure their practice to achieve maximum value. Establishing a balanced, efficient, and profitable practice model can be the difference in millions of dollars in terms of a practice value. However, with so many active buyers and acquisition preferences in the dermatology market today, it is challenging for practice owners to select which model build-out strategy produces the optimum outcome.

In completing that model build-out evaluation, there are several critical areas that a practice owner should address.

**PHYSICIAN-CENTRIC VS. MID-LEVEL-CENTRIC**

A heavily debated topic within the dermatology community today is the risks and rewards of a practice that staffs a significant number of mid-level providers, including physician assistants (PA) and nurse practitioners. The supportive argument for building a practice around a robust mixture of mid-level providers is that they can be profit centers, provide needed services to patients without the doctor being in the room, and can be great support systems for the dermatologists. Mid-level providers can also help reduce recruiting pressure, especially in areas where it is very difficult to attract specialty physicians like dermatologists. With a growing demand for dermatology services, it is becoming more mission critical to ensure a reliable stream of providers to address the growing demand.

A counter argument for a mid-level provider focused model is that a practice’s value is centered on the dermatologist. If a practice shifts more of the services to mid-level providers, then, according to some, the practice value could diminish as a result of revenue production moving away from the physician. Furthermore, it can be argued that a practice could incur increased risks and penalties from insurance companies and regulators if mid-level providers are given too much control.

Compensation and financial relationships involving mid-level providers also can be complex. For example, the extent to which mid-level supervision is compensated or implicitly considered in setting physician pay can have unforeseen regulatory nuances. Practices must pay careful attention to utilization patterns and strictly adhere to the required standards of care, regardless of the identity of the provider. Over-reliance on mid-level providers can also weaken patient relationships. To be fair, these questions are usually a matter of degree.

What is the correct answer? It depends on several factors, including the philosophies of the practice owners and the potential buyers or private investors that they may want to approach in the future.

Bart Walker, a Healthcare corporate and M&A attorney with McGuireWoods, states that, “There is no magic formula here. The variety in physician and mid-level utilization and compensation models has proliferated with the growth of professional financial management in physician specialties. Each has their own take on the right mix of providers and how to properly align economic interests toward the optimal outcome, for both the patient and the practice. Those groups who have been most successful are the ones who have constantly kept the

There are many areas to address when growing or restructur- ing a practice. For example, staffing with mid-level providers and the addition of ancillary services are all worth consider- ing, but their value is debated. Ultimately, a more stream- lined, profitable, and appropriately diversified practice will provide practice owners with a position of strength should they one day consider selling their practice.

**thebottomline**
patient at the center of their care delivery model and the physician at the center of the decision making process.”

There is support for an industry migration toward more reliance on mid-levels for production. As an example, Allergan Inc. and BSM Consulting’s annual benchmarking study among medical aesthetic, dermatology, and medspa practices shows total practice revenue generation split evenly 50/50 between physicians and all other providers in 2017, as compared to 60/40 in 2010.1 In reviewing a sample of 12 private equity-backed dermatology practices, it was found that the physician/mid-level staffing mix was 55/45. These separate studies are further evidence of the industry’s respect for mid-levels and the increasing importance mid-levels have in a dermatology practice. Figure 1 offers some insight on the Physician to Mid-level ratio at several private equity platforms.

While there is no clear consensus in the dermatology community or buyer circles, a balanced staffing model that achieves optimal profitability and quality patient service appears to be the most valued system.

**Administrative Overhead**

When potential buyers are evaluating a practice, they are heavily scrutinizing the amount of administrative overhead relative to the performance of the practice. Selling, General, & Administrative (“SG&A”) expenses, or administrative overhead, can include such expenses as front desk, billing, and compliance personnel costs (i.e., administrative personnel costs). Furthermore, electronic medical record system costs, rent, and marketing expenses can also be major components of SG&A.

Unfortunately, it is not uncommon for many dermatology practices to have higher than targeted SG&A expenses, especially if owners prefer a larger administrative staff to help run operations. While there are merits of additional staff to run operations, many practice owners often don’t understand what the appropriate level of administrative personnel costs should be in their practices. Furthermore, practice owners have difficulty ascertaining how to best streamline other SG&A costs, including marketing and technology costs.

Andrew Henoch, a Managing Director at Alvarez and Marsal’s Transaction Advisory Group suggests that, “Multi-site dermatology practices must thread the needle when managing investment in their back-office. A bloated back office without appropriate austerity measures can stifle earnings. However, underinvestment can be equally problematic and stunt opportunities for growth.” Mr. Henoch adds that, “the most successful executive teams seek timely investment in their practice’s revenue cycle management, managed care contracting, credentialing, compliance, and IT functions and personnel. Ensuring these functions are in place at the appropriate time in a company’s lifecycle allows their companies to more vigorously pursue growth opportunities, avoid costly compliance issues, and navigate the ever-evolving marketplace within multi-site dermatology.”

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**Figure 1. Private Equity-Backed Dermatology Platforms: Physician to Mid-Level Ratios**

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>No. of Physicians1</th>
<th>No. of Mid-Level Providers2</th>
<th>No. of Locations</th>
<th>Physicians to Mid-Level Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Dermatology Partners</td>
<td>180</td>
<td>66</td>
<td>64</td>
<td>2.73 to 1</td>
</tr>
<tr>
<td>Advanced Dermatology &amp; Cosmetic Surgery</td>
<td>153</td>
<td>189</td>
<td>152</td>
<td>0.81 to 1</td>
</tr>
<tr>
<td>Forefront Dermatology</td>
<td>146</td>
<td>129</td>
<td>145</td>
<td>1.13 to 1</td>
</tr>
<tr>
<td>Schweiger Dermatology</td>
<td>72</td>
<td>77</td>
<td>48</td>
<td>0.94 to 1</td>
</tr>
<tr>
<td>Dermatologists of Central States</td>
<td>69</td>
<td>45</td>
<td>58</td>
<td>1.53 to 1</td>
</tr>
<tr>
<td>Anne Arundel Dermatology</td>
<td>64</td>
<td>68</td>
<td>59</td>
<td>0.94 to 1</td>
</tr>
<tr>
<td>Qualderm Partners</td>
<td>57</td>
<td>34</td>
<td>40</td>
<td>1.68 to 1</td>
</tr>
<tr>
<td>Riverchase Dermatology</td>
<td>42</td>
<td>38</td>
<td>36</td>
<td>1.11 to 1</td>
</tr>
<tr>
<td>Pinnacle Dermatology</td>
<td>33</td>
<td>31</td>
<td>35</td>
<td>1.06 to 1</td>
</tr>
<tr>
<td>Northeast Derm. Assoc.</td>
<td>30</td>
<td>11</td>
<td>24</td>
<td>2.73 to 1</td>
</tr>
<tr>
<td>United Skin Specialists</td>
<td>18</td>
<td>21</td>
<td>9</td>
<td>0.86 to 1</td>
</tr>
<tr>
<td>Skin &amp; Beauty Center</td>
<td>13</td>
<td>10</td>
<td>6</td>
<td>1.30 to 1</td>
</tr>
</tbody>
</table>

**Mean** 1.40 to 1  
**Median** 1.12 to 1

1. Physicians include dermatologists, mohs surgeons, plastic surgeons. 2. Mid-Level Providers include physician assistants, nurse practitioners, aestheticians. Source: Practice websites
If dermatology practices are generating Adjusted EBITDA margins* less than 20 percent, then it is possible that the cause for relatively lower margins are due to excessive SG&A costs.

Cameron Cox, CEO of MSOC Health, a medical practice consulting firm, notes, “Applying analytical analysis to many of our problems around staffing, revenue management, and patient interactions, is the most effective way to understand organizational operations objectively.”

**DIVERSIFICATION OF SERVICES**

A significant reason for the wave of Mergers & Acquisitions activity in the dermatology segment is because practices can offer multiple service lines, increasing the performance of the practice and minimizing risk to a new owner. Those profit centers can include such services as medical dermatology, Mohs surgery, superficial radiation therapy, cosmetic dermatology services (such as microdermabrasion, laser procedures, hydrofacials, minimally invasive fat reduction, and hair restoration), retail products, and even plastic surgery services. Furthermore, a practice can establish a dermatopathology lab to generate revenue from lab work, or a medical spa, where cosmetic patients can visit to obtain additional medical treatments in a more relaxed setting. Figure 2 provides an overview of the market service breakdown.

With the opportunity to implement so many different offerings, which direction should a practice owner take? It would be difficult for the average independent practice to institute all offerings, but it could be highly lucrative for a practice to implement one or two additional, highly synergistic services for the benefit of its patients.

Chad Eckes, Chief Executive Officer of Pinnacle Dermatology, offered his insights. “In dermatology, it’s critical to be clear about what is driving your business and staying true to your strategy,” he says. “It’s easy for practice owners to be lured by every additional revenue opportunity from adjacent and obscure service lines but understanding the true cost of distraction from so many spinning plates vs. the revenue pick up is essential to the business’ continued success.” Furthermore, Mr. Eckes adds, “At Pinnacle, for example, the core of our business is focused on medical dermatology. We also offer complementary cosmetic service offerings to ensure that we’re able to satisfy their needs and desires so they don’t seek those services and eventually all of their dermatology services elsewhere. These complementary services differ based upon market.”

**FOUNDATIONS FOR VALUE**

While there are many areas to address when growing or restructuring a practice, the above foundations are critical to building value. A more streamlined, profitable, and appropriately diversified practice (staffing and services) will provide practice owners with a position of strength should they one day consider selling their practice. ■

Clint Bundy is a Managing Director with Bundy Group, a boutique investment bank. He specializes in representing practice owners in business sales, capital raises, and acquisitions. Clint and the Bundy Group team have an extensive track record in the dermatology and healthcare markets advising practice owners and physician groups.

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*Notes:

i. Adjusted = reflects adding back one-time, extraordinary and non-recurring expenses for a practice. Adjusted EBITDA also include adding back excess physician compensation (i.e. difference between current physician owner compensation and market compensation that the physician would be paid under a new owner).

ii. EBITDA: Earnings Before Interest Expenses, Taxes, Depreciation & Amortization

iii. Adjusted EBITDA Margin: Adjusted EBITDA / Practice Revenue
