Advisory Board

ARCHETYPE

for suppliers and service providers

Physician series | Volume 1 of 5

Physician-Owned Medical Group

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Key takeaways

- A physician-owned medical group is wholly or partially physician-owned and not owned by a hospital, insurance company, or practice management company
- Organizations operate in a variety of reimbursement models including traditional fee for service, concierge medicine and value-based contracts.
- Private equity firms are acquiring and consolidating physician-owned medical groups, offering rapid growth potential and accelerating the outmigration of care
- Both public and private payers are partnering with physician-owned medical groups in an attempt to provide financial support and prevent further consolidation arguing that keeping these groups independent from hospitals will lower costs of care

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PHYSICIAN ARCHETYPE SERIES

VOLUME 1

Physician-Owned Medical Group

Preview: A medical group that is wholly or majority physician owned, physician-governed, and not operated by a hospital, insurance company, or practice management company

VOLUME 2 To come

Enablement Partner

Preview: A private corporation that provides centralized, scalable business resources through a subscription service or investment in a medical group's managed service organization (MSO)

VOLUME 3 Read here

National Medical Group Franchise

Preview: A national, for-profit care delivery organization that is not owned by a hospital or health system

VOLUME 4 Read here

Virtual Care Organization

Preview: A care delivery organization that only offers telemedicine services

VOLUME 5 Read here

Health System-Owned Medical Group

Preview: A single or multi-specialty group of physicians employed by a hospital or health system

Physician Archetype Series Comparison Chart

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Who they are

A medical group that is physician led, wholly or partially physician-owned and not owned by a hospital, insurance company, or practice management company. Groups are all for-profit, but vary in size and level of market influence.

Physician-owned medical groups can be single or multi-specialty. While most groups serve a local market, some have grown either organically or through mergers and acquisitions to cover a larger region.

How do these groups make money?

Physician-owned medical groups bill payers for professional (physician) service. Depending on the specialty, this can be evaluation and management (E/M) codes or procedural services. Some physician-owned groups may also bill for technical services. For example a radiology group that owns and operates an imaging center would bill both for the professional component of reading radiology images and the technical component for performing the scans.

Physicians within the group provide care at group-owned sites or at hospitals where they have privileges to practice. Single and multi-specialty groups that primarily bill for medical consults and other office-based services tend to practice in their own facilities. Other physician groups provide care at hospital or health system-owned facilities. This is particularly common for single specialty groups like anesthesiologists and internists. In some instances, medical groups—particularly radiologists—might negotiate their role as the exclusive provider of that specialty for the hospital. Finally, some groups, particularly proceduralists, combine both approaches, providing care in hospital facilities as well as their own ambulatory sites.

In an effort to diversify their revenue, some physician-owned medical groups have spun off separate LLCs to operate larger scale ventures such as a management services organization or a technology solution.

1. Advisory Board Integrated Medical Group Benchmark Generator 2019.

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What's the group's relationship with physicians?

Some or all physicians are shareholders, or owners, of the group. These physicians hold equity in the group and vote on major decisions.

There is a wide range of compensation models for physicians, but they all try to balance productivity with the cost of running a medical group. Three common approaches are:

1. A **net collection model** where compensation is individual physician revenue with practice expenses or overhead subtracted
2. A **combination of productivity-based earnings** (net collections or wRVUs) **and non-productivity incentives** (e.g. group citizenship, patient satisfaction)
3. A benchmarking system using a **Total Medical Expense Multiplier (TME) to adjust physician payment** based on their contribution to the medical group's overall performance in risk-based contracts

Physician-owned medical groups may also employ physicians who are not shareholders. They pay these physicians in a salary-based model, but many still include non-productivity metrics as part of compensation.

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What makes them different

In a physician-owned medical group, physicians are shareholders and any large expenses reduce physician revenue. As a result, while physicians have influence on purchasing, they highly scrutinize any large purchases. Physician-owned medical groups tend to operate in a limited geographical area and have priorities that are market specific. This is in contrast to national medical groups and virtual care organizations which operate in multiple markets.

Individual physicians can provide input on clinical standardization and purchasing efforts, giving physicians in these groups more autonomy than in many other physician entities.

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Key decision-makers

What is the group's governance structure?

While certain decisions require votes from all shareholders, to streamline decision-making, physician-owned medical groups are largely governed by boards. Typically, shareholders elect ten or fewer board members from the larger medical group.

The medical group board makes decisions on:

- Strategy
- Business development
- Physician compensation
- Acquisition or divestiture moves
- Capital and operating budgets

The board chair is a physician leader who spends about half of their time in this role. The board chair sets the board meeting agendas, facilitates discussion, and represents the board to shareholders.

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What is the group’s management structure?

Physician boards collaborate with an administrative CEO to guide the group. The CEO is typically not a physician but has strong business and practice management expertise. The CEO reports to the entire board. The board has governance duties and focuses on vision and oversight for the group. The CEO has management duties and focuses on execution. For example, while the board likely approves capital and operating budgets for the group, the CEO develops and manages the budget.

Larger groups may delegate tasks to committees. These committees are also made up of physicians, allowing for more to participate and serve in leadership positions. Some committees focus on governance matters like quality, finance, or strategic planning. Others focus on administrative issues including physician recruitment, marketing, and technology.

How much autonomy do physicians have in purchasing decisions?

The board has broad autonomy to make decisions on large purchases and may look to guidance from the CEO. Individual physicians, however, typically do not have the authority to make large purchases. They may authorize smaller purchases. However, given that all shareholders are concerned with maximizing shareholder value, they will look for purchases that are cost effective and improve care efficiency and quality.

How much autonomy do physicians have in clinical standardization efforts?

Physician-owned medical groups may be more nimble than health system-owned or other organizations at implementing clinical standardization efforts. Particularly in groups with a robust committee structure, physicians can be involved and suggest clinical standardization efforts.

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Three market trends to watch

01

TREND

Private equity is betting on physician-owned medical groups

02

TREND

Payers partner with physician-owned groups to lower costs

03

TREND

Sustaining independence from hospitals requires scale and capital

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01 Private equity is betting on physician-owned medical groups

Private equity firms are investing heavily in medical groups, offering rapid growth potential and accelerating the outmigration of care. As a result of this investment, many of these physician-owned medical groups are no longer wholly-physician owned, as they have sold some portion in exchange for capital.

The previous focus of private equity transactions were non-core specialties like dermatology, ophthalmology, dentistry, and anesthesia. More recently, private equity firms are investing in procedural specialties like gastroenterology, urology, orthopedics, and women's health. These firms hope to capitalize on the ongoing outmigration of care, and enable medical groups to pull procedures from the hospital into lower-priced outpatient settings.

In exchange for equity and potentially board seats, the medical group receives upfront capital to fund acquisitions and service expansion. The typical investment period for these transactions is 3-5 years, after which the private equity firm will resell the medical group equity to another firm at a higher value.

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02 Payers partner with physician-owned groups to lower costs

Both public and private payers are partnering with physician-owned medical groups in an attempt to lower health care costs and keep these medical groups from hospital employment. Payers believe these physician-owned medical groups can use their referral leverage to ensure patients receive only high value, low cost care or offer care at a lower-cost than hospitals and health systems.

Private payers and employers were already steering patients to lower-cost facilities owned and operated by medical groups using care navigation tools and advertising lower patient obligations. Now, more private payers are engaging medical groups in risk-based models and some even offer practice support like clinical pathway tools that help medical groups successfully compete for commercial and Medicare Advantage beneficiaries.

In 2019 CMS developed “Primary Cares,” two value-based care models aimed at physician-owned medical groups. To encourage medical groups to participate, CMS built in salary enhancements and projects that a PCP making $200K today could make $300K under the new model. CMS expects to build on the 2018 ACO results, which showed that 77% of physician-led ACOs generated total savings, compared to just 58% of health system-led ACOs.

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03 Sustaining independence from hospitals requires scale and capital

To remain independent from hospitals, physician-owned medical groups are in an ongoing growth cycle that is both fueled by, and requires a continual focus on, both scale and capital. For physician-owned medical groups to remain independent of hospitals or national practice companies, they need to:

- Gain contracting leverage with hospitals and payers,
- Build effective centralized business functions like EHRs, and
- Successfully engage in population health.

All of these require both access to capital and a level of scale to be successful. Some physician-owned groups look to private equity for scale and capital, while others look to traditional sources such as debt financing, real estate sales with lease back, and retained earnings. Other groups look to merge with other physician-owned to gain economies of scale. Overall, the size of the median medical group grew 25% from 2013-2015. Aside from formal mergers and acquisitions, medical groups may partner to fill service gaps or participate in value-based arrangements.

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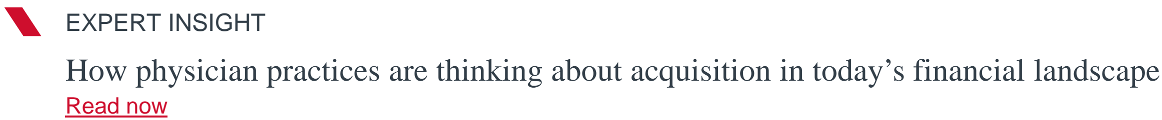

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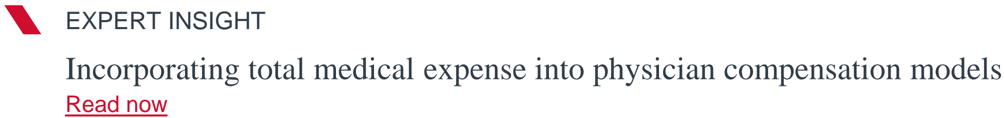

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