A Tale of Two Recoveries
MEDICAL PRACTICE OWNERSHIP AND COVID-19

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A Tale of Two Recoveries

EXECUTIVE SUMMARY

No one in healthcare escaped the dramatic impacts of the COVID-19 pandemic, but quantitative research and stories from the front lines of care delivery make it clear: The response and recovery looked significantly different between physician group practices and hospital-owned entities.

Common threads united healthcare provider organizations since early 2020: concern for patient and staff safety, heightened stress, uncertainty, burnout and — eventually — the feelings of relief as safe and effective vaccines rolled out to begin controlling the spread of the coronavirus.

Yet as the industry’s recovery continues, there are stark differences in the financial realities for medical practices throughout 2020, largely divided on lines of practice ownership.

The 2021 MGMA Cost and Revenue survey report collected data on more than 4,000 organizations from a variety of specialties and practice types, serving as a baseline for benchmarking 2021 operations.

This data report reveals key trends from this new survey report, paired with expert insights from industry leaders and MGMA member feedback, to round out the history of healthcare’s 2020 pandemic response and guide practice leaders as they strategize for the post-pandemic future in 2022 and beyond.

ABOUT MGMA

Founded in 1926, the Medical Group Management Association (MGMA) is the nation’s largest association focused on the business of medical practice management. MGMA consists of 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA helps nearly 60,000 medical practice leaders and the healthcare community solve the business challenges of running practices so that they can focus on providing outstanding patient care. Specifically, MGMA helps its members innovate and improve profitability and financial sustainability, and it provides the gold standard on industry benchmarks such as physician compensation. The association also advocates extensively on its members’ behalf on national regulatory and policy issues.

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DATA TRENDS

Productivity

All practice types in the 2021 MGMA Cost and Revenue survey report had pronounced decreases in productivity levels in 2020 versus 2019, though hospital-owned practices fared much worse. While physician-owned practices saw total encounters per full-time-equivalent (FTE) physician decline from 10.72% to 18.07% from 2019 to 2020, the percentage decreases with the same practice types among hospital-owned entities for the same period were three times greater on average (Table 1).

<table>
<thead>
<tr>
<th>Practice type</th>
<th>Physician-owned</th>
<th>Hospital-owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>-10.72%</td>
<td>-38.48%</td>
</tr>
<tr>
<td>Nonsurgical</td>
<td>-18.07%</td>
<td>-50.27%</td>
</tr>
<tr>
<td>Surgical</td>
<td>-12.88%</td>
<td>-35.65%</td>
</tr>
</tbody>
</table>

Sources: 2020 and 2021 MGMA DataDive Cost and Revenue (based on 2019 and 2020 data)
TABLE 2. DIFFERENCE IN TOTAL MEDICAL REVENUE PER FTE PHYSICIAN, 2019-2020

<table>
<thead>
<tr>
<th>Practice type</th>
<th>Physician-owned</th>
<th>Hospital-owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>-$78,102</td>
<td>-$12,872</td>
</tr>
<tr>
<td>Nonsurgical</td>
<td>-$175,891</td>
<td>-$5,555</td>
</tr>
<tr>
<td>Surgical</td>
<td>-$90,972</td>
<td>-$37,312</td>
</tr>
</tbody>
</table>

Sources: 2020 and 2021 MGMA DataDive Cost and Revenue

However, despite hospital-owned practices seeing the most significant drops in total encounters throughout 2020, these practices saw significantly lower decreases in total medical revenue compared to their counterparts in physician-owned practices (Table 2).

FIGURE 3. DIFFERENCE IN TOTAL ENCOUNTERS PER FTE PHYSICIAN

Though provider-level data collected in the 2020 MGMA Monthly Survey saw a return to normal levels of compensation for some summer months and toward the end of 2020, the damage inflicted by shutdowns, quarantine and overall economic downturn in the early months of the pandemic was unmistakable.

Even with rapid expansion of telehealth and other innovative approaches taken to stay afloat, the lower productivity levels throughout 2020 stifled total medical revenue per FTE physician for the year.

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Like the survey report’s findings on total medical revenue, hospital-owned practices in surgical and nonsurgical specialties fared much better during the pandemic year than their physician-owned counterparts (Table 3). However, physician-owned primary care and multispecialty groups each posted improvements in this key metric from 2019 to 2020.

One explanation for this significant variance might be the traditional compensation models underpinning many physician-owned practices that see a direct link between higher volumes and higher pay: With financial viability on the line as businesses awaited word on federal relief programs, physician-owned groups quickly pivoted to telehealth and other innovative care delivery models to keep physicians, providers and staff working even as patients were told to stay at home in the early months of the pandemic.

In some cases, the significant decrease in the gross charges in physician-owned practices may not be a result of a decrease in professional services but rather a decrease in ancillary services. Converting several appointment types from in-person care to telehealth/virtual visits may have had a profound impact on practices’ ability to migrate patients to ancillaries throughout 2020.

**FIGURE 4. 2020 MONTHLY CHARGES AND COLLECTIONS PER FTE PHYSICIAN, SURGICAL SPECIALTY PRACTICES**

The sharp drops in gross charges for surgical specialty practices on both sides of the ownership divide reflect what MGMA previously learned in the 2020 Monthly Survey, in which professional gross charges saw two significant dips in 2020: A steep, sudden drop in April 2020, and then a gradual decrease from August through October 2020.

<table>
<thead>
<tr>
<th>Practice type</th>
<th>Physician-owned</th>
<th>Hospital-owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>3.11%</td>
<td>-0.35%</td>
</tr>
<tr>
<td>Nonsurgical</td>
<td>-15.01%</td>
<td>1.53%</td>
</tr>
<tr>
<td>Surgical</td>
<td>-17.79%</td>
<td>-2.40%</td>
</tr>
<tr>
<td>Multispecialty</td>
<td>8.21%</td>
<td>-2.95%</td>
</tr>
</tbody>
</table>

Sources: 2020 and 2021 MGMA DataDive Cost and Revenue
Operating expense

Another key element to physician-owned practices’ impetus for achieving robust levels of productivity amid the pandemic is the impacts of costs associated with ensuring employee and patient safety, which are felt more directly for smaller, physician-owned practices that might monitor costs with greater frequency and/or attention than some hospital- or system-owned practices where elements of costs are rolled into the larger organizational budget.

The 2021 MGMA Cost and Revenue survey report finds that physician-owned practices saw modest increases in total operating costs in 2020 versus 2019 levels (Table 4), with surgical specialties reporting a 13.83% one-year increase in costs as practices scrambled to acquire adequate personal protective equipment (PPE), cleaning supplies and other provisions for ensuring safety during the pandemic.

For hospital-owned practices, the survey report pointed to a robust ability to slash operating costs in 2020. These total operating cost figures include total support staff costs, as well as total general operating expenses. This signaled the ability of some larger organizations to shut down entire departments during the pandemic as lockdowns caused visit and procedure cancellations or delays, and subsequently shifted needed clinical and administrative staff to high-acuity, high-need areas while organizations furloughed or laid off other staff to adjust to lower staffing needs.

**TABLE 4. DIFFERENCE IN TOTAL OPERATING COST PER FTE PHYSICIAN**

<table>
<thead>
<tr>
<th>Practice type</th>
<th>2019-2020</th>
<th>2016-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician-owned</td>
<td>Hospital-owned</td>
</tr>
<tr>
<td>Primary care</td>
<td>2.69%</td>
<td>-6.42%</td>
</tr>
<tr>
<td>Nonsurgical</td>
<td>5.61%</td>
<td>-2.53%</td>
</tr>
<tr>
<td>Surgical</td>
<td>13.83%</td>
<td>-7.95%</td>
</tr>
</tbody>
</table>

Sources: 2017, 2020 and 2021 MGMA DataDive Cost and Revenue (based on 2016, 2019 and 2020 data)

**FIGURE 5. DIFFERENCE IN TOTAL OPERATING COST PER FTE PHYSICIAN**

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Another element crucial to understanding the shifts in operating costs during 2020 was the ability to secure adequate supplies of PPE as the market for items such as masks, gloves, gowns and other protective gear surged.

**MGMA Stat polling from August 2020**

found almost universal increases in PPE costs across healthcare. Data from nearly 300 practices facing increased costs found that the increases ranged from more than 100% increases in PPE costs to more modest growth in spending:

- 15% reported cost increases of 101% or more.
- 16% reported costs rising 41% to 50%.
- 19% saw increased costs of 21% to 30%.
- 13% saw costs go up 11% to 20%.

Though demand for PPE has decreased from its peak in 2020, **some infectious disease experts are warning of continued spread of highly transmissible variants of the 2019 coronavirus and potential surges of new cases despite the success of vaccination efforts to date.**

A spike in new cases in areas with high rates of unvaccinated individuals could prompt additional demand for PPE for healthcare workers, other industries and the public, in addition to shortages of ventilators and other key clinical equipment and supplies for treating a surge of COVID-19 cases. In states such as Missouri, which had a **caseload around 108 cases per 100,000 people in early July**, there are large spikes of the Delta variant.

Lawrence Gostin, director of the World Health Organization’s Collaborating Center on National and Global Health Law, recently said he could foresee “a reintroduction of indoor mask mandates” during a “very dangerous fall” in which millions of Americans remain unvaccinated.
INDUSTRY INSIGHTS

COVID-19 and consolidation in healthcare

Despite the severe extent to which the COVID-19 pandemic disproportionately affected hospital-owned practices’ productivity and revenue metrics, the overall fortunes of independent medical groups and hospital-owned entities appear on the same trajectory as they were pre-pandemic.

The waves of consolidation via mergers (for horizontal and vertical integration) and acquisitions (including growing ownership of practices by payer entities and private equity) briefly ebbed at the beginning of the pandemic, only to return to previously seen levels toward the end of 2020 and beyond. By December 2020, a Deloitte report pointed to the top 10 health systems controlling almost a quarter of the entire market — with more rapid consolidation of health systems on the horizon.

This trend has significant implications for the ways in which America’s physician workforce performs its crucial work in directing care delivery while the healthcare ecosystem grapples with efforts to contain costs and promote better outcomes for patients.

BY THE NUMBERS

- The American Medical Association’s (AMA) Physician Practice Benchmark Survey — conducted in September and October 2020 — found that only 49.1% of patient care physicians work in physician-owned practices, down from 54% in the AMA’s 2018 survey. Similar AMA surveys have pointed to this trend going back to 2012, but the five-percentage-point drop from 2018 to 2020 points to an acceleration of this shift.

- A separate study by the Physicians Advocacy Institute, conducted between Jan. 1, 2019, and Jan. 1, 2021, found about 48,400 physicians left independent practice for a larger employer (e.g., hospital or corporate-owned practice) during that time. Specifically, the report found that more than half of the 18,600 physicians who left independent practice for hospital employment did so during the pandemic.

The consolidation trend is also pronounced with hospitals. The American Hospital Association estimates that hospitals could lose between $53 billion and $122 billion in 2021 on top of losses from 2020; financially struggling hospitals may seek partnerships or become the targets of better-performing organizations seeking to grow their markets. A Q3 2020 report on healthcare M&A activity from Kaufman Hall noted that “the pandemic had little impact on the pace” or interest in M&A deals among health systems and not-for-profit hospitals.

In fact, consulting firm RSM pointed to a flurry of healthcare and life sciences deals at the outset of 2021 as potential for this year to be the “busiest year yet” for partnerships, joint ventures and other M&A activity.

Charting the future

Kaufman Hall’s latest quarterly data point to larger hospitals and health systems within a region pairing up, rather than larger organizations buying up smaller hospitals and groups. At the same time, President Joe Biden’s July 9 executive order encourages the Department of Justice and Federal Trade Commission to step up antitrust enforcement, specifically citing “unchecked mergers” of hospitals. As noted in the executive order, the Administration has concerns about provider consolidation leading to higher prices and the trend of rural hospitals closing.
But not all M&A activity is centered on larger organizations. There are a number of smaller and mid-sized physician practices that have innovated during the pandemic and poised for growth.

As Erich Koch, FACHE, FHIMSA, CPA-ND, CMPE, chief financial officer and interim chief executive officer, Tyler Family Circle of Care, Tyler, Texas, noted in a November 2020 MGMA Stat data story, his practice has been participating in more value-based and risk-based programs, and gaining market share and patient panel can help the group go back to payers to seek better rates in contract negotiations.

That November 2020 MGMA Stat poll found only 12% of practice leaders said their practices’ ownership status changed in the past year, and of the remaining 88%, only 8% said they were considering a change in 2021.

For the 12% that did see an ownership change in 2020, less than a third said it was a sale to a hospital, health system or private equity firm, whereas the majority (51%) pointed to new partners joining, and another 7% merging with another practice.

A July 13 MGMA Stat poll gives us our most up-to-date look at ownership and M&A trends, in that only 15% of practices completed M&A activity in the past year, with only 5% considering it.

For physician practices, there remains a path for not just survival as an independent group — careful and strategic consideration of new opportunities in acquiring new physicians — and sometimes pursuing mergers, joint ventures and acquisitions — can lead to sustainable success.
PRACTICE M&A LESSONS
In her recent 2021 Medical Practice Excellence: Pathways Conference session, Aimee Greeter offered five lessons — drawing on case studies of mergers and acquisitions — about trends in healthcare M&A:

1. Begin by determining your reasons (the “why”)
2. Understand your options (the “what”)
3. Educate yourself on the process (the “how”)
4. Seek a partner (the “who”)
5. Ensure successful implementation (the “when”).

KNOWING THE “WHY” — EYESOUTH PARTNERS AND EYE CENTER OF TEXAS
In December 2020, EyeSouth Partners — a historically strong eye care management services organization (MSO) — completed an affiliation with Eye Center of Texas. As Greeter explained, EyeSouth expanded its reach across Texas while Eye Center of Texas got the support functions associated with a strong MSO.

“Eye Center of Texas recognized that they had some challenges that were unveiled as a result of COVID,” Greeter said. “COVID has shined a very bright light in areas where there may have been a lack of efficiencies or maybe suboptimal performance.” This pairing allowed Eye Center of Texas to bring in efficiencies they lacked and grow quickly while still retaining levels of independence and autonomy.

Greeter outlined several potential reasons for medical practices and other healthcare provider organizations to pursue mergers in the current market:

• Achieving economies of scale
• Spreading of risk/cutting costs/increasing synergies
• Acquisitions of cash or building excess debt capacity
• Flexibility and leverage
• Growing leadership potential and/or succession planning
• Gaining new competencies/talent/knowledge from another organization
• Defensive strategy for competition and/or achievement of critical mass
• Improving recruitment potential and attractiveness to potential employees/providers
• Asset growth for potential investors.

“Until you really understand the whys of what you’re trying to do, I think you have to be really, really careful to not go full bore into doing the transaction,” Greeter cautioned.

UNDERSTANDING THE “WHAT” — COMMUNITY CARE PHYSICIANS AND CAPITALCARE MEDICAL GROUP
Greeter noted that healthcare organizations typically seek one of two major types of merger structures:

1. A legal merger, in which a new legal entity is created, with groups operating under a single Taxpayer Identification Number (TIN) despite having operational variances and “pod” mentalities between the entities.
2. An operational merger, in which operations, economics and governance are consolidated within a new company, followed by a process of standardization across most function areas (e.g., clinical and business). “The operational merger is where we truly try to integrate our cultures … and we try to bring people together,” Greeter said.
In 2018, Community Care Physicians and CapitalCare Medical Group — independent multispecialty practices near Albany, N.Y. — combined to create a single, integrated group composed of 420 providers across 80 locations and 30 specialties. Specifically, CapitalCare practices became divisions of Community Care; however, they maintain their practice names and have distinct cultural differences across practices.

“I think this is a good example of knowing what you want, why you’re doing something, but then making the ‘what’ accommodate those reasons,” Greeter said of the hybrid merger in which the organizations achieved economies of scale while maintaining practice independence.

Of course, another alternative to a legal, operational or hybrid merger is an acquisition (e.g., outright or purchasing a majority interest). “There may be more give-and-take in a merger; in an acquisition it tends to be more of a top-down model where someone is going to have majority or super-majority control,” Greeter said.

Other hybrid models might include professional services agreements (PSAs).

### AIMEE GREETER’S NINE STEPS TO AN M&A DEAL

1. **Determine your long-term goals and set reasonable expectations for M&A.** This involves understanding the “why” of a deal, your objectives and what you’d be looking for in a partner.

2. **Become educated on alternatives** and determine what strategy is right for you.

3. **Identify potential partners and highlight areas of opportunity and potential challenges.** As Greeter noted, fixating on one potential partner and only doing research into that entity can be “limiting in terms of your overall success.” Instead, “look to have multiple potential partners to find the best possible deal,” Greeter added.

4. **Complete operational and financial due diligence on the deal, including valuations as necessary.** “The due diligence process is often the most painstaking for medical practices, because it requires you to come up with what feels like volumes and volumes and volumes of information that’s been shared with your potential partner,” Greeter said, but it’s vital to the overall success of an eventual deal and can yield significant insight into why the other entity is considering a deal.

5. **Submit term sheets/offer scenarios (letters of intent).** Greeter said she always tries “to strike first” by extending an initial term sheet with your own economic and non-economic terms to a deal. “We put ourselves out there first; we think being an aggressor makes it easier for the other party to then respond fully and completely to what we’re asking,” Greeter added. That document then serves as a basis for discussions going forward.

6. **Negotiate terms and conditions of merged entity.** In this phase, you will discover terms that seemed insignificant at the beginning of talks that now take on new prominence. If you’re negotiating out terms, “a good healthcare attorney will be worth their weight in gold,” Greeter said.

7. **Initiate post-merger integration initiatives, development of business plan.** This can involve talking about the mission and vision, the organizational model of the new entity, as well as development of a capitalization structure.

8. **Close transaction:** legal formation of merged entity.

9. **Complete post-merger integration (transitioning).**

### UNDERSTANDING THE “HOW” — ANTITRUST ENFORCEMENT


After St. Luke’s acquisition of Saltzer’s assets and development of a PSA with the physicians, the Federal Trade Commission (FTC) and Idaho Attorney General filed an antitrust claim, with two of St. Luke’s competitors serving as plaintiffs, arguing that the transaction did not meet the best interests of the community.
Ultimately, the U.S. District Court for the District of Idaho ruled in favor of the FTC, citing Section 7 of the Clayton Antitrust Act of 1914 and the Idaho Competition Act. Ultimately, the St. Luke’s acquisition of Saltzer would control about 80% of the primary care in Nampa and make it highly likely that costs would rise given their market control. Greeter noted that the entities were forced to unwind the deal based on a judge’s order.

Though not common, this case study underscores the potential for regulatory action on antitrust compliance, Greeter said, and that healthcare leaders considering M&A deals should ensure regulatory analyses and other documentation are completed to support a transaction.

**UNDERSTANDING THE “WHO” — UNITYPOINT HEALTH AND SANFORD HEALTH**

Understanding your partner in an M&A deal is incredibly important. Greeter pointed to what she described as “one of the biggest mudslinging cases” she’s seen in the case of UnityPoint Health and Sanford Health, which involved a formal partnership being called off in 2019 after months of discussion.

When the discussions dissolved, Sanford executives publicly called out the UnityPoint team, saying in a statement, “We are disappointed that the UnityPoint Health board failed to embrace the vision” for the potential partnership. This prompted a lot of press attention beyond what would have been expected for such a large deal, which would have resulted in one of the largest nonprofit health systems in the country), Greeter noted.

While the details of what led to this public fallout remain behind closed doors, Greeter said it speaks to the need to have a strong understanding of a potential M&A partner. If cultures don’t align or there are other major points of disagreement, having a deal fall through can be like dodging a bullet, she said.

Common pitfalls for M&A deals include:

- Lack of necessary effort, leadership and capital in the M&A process
- Lack of consistent buy-in within individual practices
- Inaccurate expectations regarding timing of a deal and integration
- Inaccurate expectations regarding the scope of investment needed by providers or practices
- Inaccurate expectations of financial benefits (immediate, near and long term).

In her work, Greeter says it’s best to do some form of quantitative analysis that looks at major global issues in a potential deal (e.g., structure, operations, governance, finance, clinical operations, facilities) along with more specific issues, such as managed care reimbursement, income distribution plans, human resources efforts and information technology, ranked on a scale of one to five on how closely aligned the parties are.

“Putting down our ranking of where each organization sits individually and how [multiple potential partners] compare to each other can be an extremely valuable exercise to go through,” Greeter said. “Quantifying the cultures and what you are looking for out of a transaction is an extremely relevant and beneficial exercise for people.”

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UNDERSTANDING THE “WHEN” — OPTUM AND ATRIUS HEALTH

Optum previously submitted a bid for Atrius Health — a 715-physician, 30-location group based in Massachusetts — in 2019, but it wasn’t until after the pressures of COVID-19 that Optum signed a definitive agreement to acquire the group in March 2021.

This goes to show that even deals that may not work out initially but make sense for one party could just be a matter of not having the proper conditions or motive on both sides, which can change over time.

Greeter mentioned one of her clients who had a deal not go through initially, but in two years their Medicare Advantage (MA) contracts became much more lucrative after enrolling 34,000 more patients and doing a very good job of managing them for risk-based and capitated contracts.

“It became extremely valuable, even more lucrative than it would have been originally,” Greeter noted. “The timing always matters in terms of these transactions.”

CONCLUSION

M&A activity is nothing new to the industry, even if the pace of consolidation has picked up during the COVID-19 pandemic, Greeter said. However, the complexity of deals and the levels of antitrust scrutiny have grown in recent years, as new players enter the market. Going into a potential deal — as a buyer, seller or another player in the transaction — requires an open-eyed approach with lots of information about what you want, Greeter said.

“Make sure that you’ve got the right team in place that’s going to carry out your vision; make sure that you’ve got the timing down of when to do your transaction and when you roll out some of the post-transaction implementation methodologies,” Greeter said. “All of those things matter.”

ADDITIONAL RESOURCES

- **MGMA Benchmarking Data** — Understand the past and present to propel your practice into the future with industry-leading data analysis, reports and surveys.
- **MGMA Consulting** — Get an organizational tune-up and overcome new challenges with the help of experts in medical practice management.
- **Ask an Advisor** — Turn to this MGMA member-benefit service to get subject-matter expert guidance on a range of topics.
- **Medical Practice Excellence: Leaders Conference** — Connect with industry-leading experts and peers to learn and grow. In-person Oct. 24-27 in San Diego, or Digital Experience (DX) Nov. 16-18.
- **MGMA Podcasts** — New episodes each Wednesday and Friday, plus monthly Executive Session episodes, wherever you get your podcasts.
- **MGMA Stat** — Join the conversation among frontline healthcare leaders, with real-time data at your fingertips each Thursday.
- **MGMA Insights** — The latest MGMA resources, analysis, news and more delivered to your email inbox each Tuesday.

REAL-TIME DATA

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