# Avoiding Hospital Acquisition: A Descriptive Case Study of a Private Medical Practice

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**ABSTRACT**

This qualitative descriptive case study spotlights a flourishing privately-owned medical practice that has effectively circumvented the vertical integration trend in U.S. healthcare. A.B.C. Sports Medicine (A.B.C.) has experienced sustained growth in the number of healthcare providers, locations, and employees while remaining highly profitable, delivering excellent patient outcomes, and maintaining physician ownership. The study details practice management issues related to marketing evolution, practice growth, and management structure. A.B.C. leveraged its competitive advantages and best practices to address these issues without becoming system-owned. A.B.C. transitioned to executive board management and now needs to capitalize on marketing opportunities and determine a clear path to future growth. This study considers a new perspective on hospital acquisition of private practice. It describes a successful business model based on a strong core competency and details the competitive advantages and best practices that sustain physician ownership. The methodology for this case study encompasses private document analysis, interviews with partner physicians, the C.E.O., and the business office, and a comprehensive literature review of available research on vertical integration. This study recommends directions for future research in private practice management and explores avenues for continued success in a long-term private practice model. Key discoveries include benefits and challenges associated with private ownership, implications of team culture in business, and the synergistic value of multi-specialty collaboration.

*Keywords:* vertical integration, hospital acquisition, private practice, physician ownership, healthcare, system-owned, quality outcomes, medical practice management.

## INTRODUCTION

This case study is significant because it considers the business side of private practice management from both a patient quality and profit basis. One aspect of healthcare in the U.S. that is often sidelined is that for-profit hospitals and clinics largely conduct it. Healthcare in the U.S. is a uniquely complex business, and physician groups want to achieve excellent patient care while remaining profitable. The research sought to answer the questions: Can a private physician-owned specialty practice stave off hospital acquisition and successfully provide quality patient care and above-average profits for the physicians? How are physicians and patients affected when a hospital or hospital system buys a private specialty physician practice? And can a private practice stay private, grow, and thrive in the highly regulated healthcare industry in the U.S.?

The methodology for this qualitative instrumental case study utilized private document analysis, interviews, and an extensive literature review to develop a clear understanding of the reasons behind one practice's ability to stay privately owned, grow, and prosper in a healthcare environment dominated by increasing hospital-acquisition of physician groups. Through a review of private documents, including productivity reports, billings and collections reports, patient metrics including patients per clinic and per-patient billing, durable medical equipment collections, physical therapy (PT) referrals, ICD-10 coding benchmarks, and practice investments, a complete financial picture of the practice emerged. Interviews with A.B.C.'s C.E.O., partner physicians, and business office personnel provided insight into the structure and culture of the practice. A literature review revealed related research on the topic of private physician practice management success, the volume of practice transitions to hospital-owned entities, the financial effects of vertical integration on physicians, and the effects of such a transition on patient satisfaction, outcomes, and cost of healthcare. Official medical sources like the American Medical Association (AMA) provided earnings benchmarks across the specialties to corroborate the findings of the high profitability of the practice. These methods were selected for their appropriateness as this paper is more concerned with the business practices, financials, and patient outcomes; a review of the partnership's business documents most thoroughly accomplished the aim. The literature review identified occurrence rates, effects, and successes related to vertical integration and reinforced the prevalence of hospital acquisition and its potential negative consequences. Limitations included the limited geographic scope of the study, difficulty quantifying patient outcomes, lack of access to similar private practice's financial documents for comparison, and the requirement to fully blind the study. Due to privacy concerns, all identifiers, including names and locations, were changed and protected to ensure anonymity.

Findings demonstrated that three key components emerged as strong drivers of success and growth for the practice. These drivers allowed A.B.C. to retain the ability to operate as a private entity, demonstrate above-average growth and profitability, and provide exceptional patient care and outcomes while rebuking multiple buyout attempts in a healthcare market dominated by hospital-owned practices. Firstly, A.B.C. has a unique operating model whereby the whole is truly more significant than the sum of its parts. By operating as a practice focusing on sports medicine, they have created a uniquely efficient screening system in which patients only see a surgeon if they have already been evaluated by one of the sports medicine doctors. Second, the practice has been the healthcare provider for the popular professional sports team, the Anytown Bucks, for 20 years; this relationship provided a unique competitive advantage that

has and will continue to benefit the practice for years to come with respect to its effects on the reputation of the practice. Finally, the physician partners have created a unique culture that thrives on teamwork; business owners operate as a team with a mindset toward constant improvement and innovation.

The case concludes with two specific recommendations for continued success and improvement within the practice and suggestions for further research.

## BACKGROUND

The background content was revealed through individual interviews with founding partners, business office staff, and the new C.E.O. Over the past few years, A.B.C. has grappled with several challenging issues, including how to grow the partnership, expand the practice, partner with or sell to a hospital system, shift management to an executive board, and combat threats from competitors. In the past two years, A.B.C. has grown from seven to ten partners, and without a formal structure for a partnership track, the founding partners had to add new partners on an ad hoc basis (A.B.C. partner, personal communication, March 15, 2021). They have also hired seven additional physicians, constructed a new building, and added three additional locations to the original two (A.B.C. partner, personal communication, March 15, 2021). One incredibly unique and almost unheard-of aspect of this organization is that for eighteen years, it was run solely by physician partners; an executive board was created in 2022, bringing with it both opportunities and growing pains (A.B.C. partner, personal communication, December 20, 2022). Until now, partners have had to function as physicians and businesspeople, executing all investment, human resources, and business decisions with only advisory help from their practice attorney and business office consultant (A.B.C. partner, personal communication, December 20, 2022). Adopting an executive board will allow them to refocus on their core competency: providing exceptional comprehensive patient care.

The practice was established as an S corporation and is still run that way in 2022. According to the AMA, S corporations are the second most common business structure for group practices following closely behind limited liability corporations at 24.7% and 27.8%, respectively (American Medical Association, 2021). The partners have contemplated and rejected offers to partner with or sell to a major hospital system and have decided to remain privately owned (A.B.C. partner, personal communication, March 15, 2021). An annual update and evaluation of the organizational SWOT Analysis has consistently reinforced the belief that both patient quality of care and physician profits will likely suffer if they sell to a hospital system.

Local and regional competition is growing within the sports medicine field. One competing group has aggressively pursued care of high school athletes and has consistently failed due to A.B.C.'s close relationships with the athletic trainers and coaches (A.B.C. partner, personal communication, March 15, 2021). A.B.C. physicians attend every local high school football game and offer Saturday morning clinics for football injuries as well as school sports physicals on local high school and university campuses (A.B.C. partner, personal communication, March 15, 2021). This kind of community involvement has solidified their dominance in high school athletic care. A.B.C. also has a significant presence with local collegiate and professional athletes. A large academic healthcare system recently contracted to assume the mantle of the official healthcare providers of the Anytown Bucks, which will be effective January 1, 2024 (A.B.C. partner, personal communication, December 20, 2022). A.B.C.

physicians have cared for and traveled with the Bucks for over 20 years. A.B.C. decided not to pay to continue treating the Bucks. A.B.C. will continue to operate as the team physician for the Bucks through 2023. They will have to adapt to the reputational impact of this change. All these dynamics represent threats to the practice revenue.

## DESCRIPTION

The study participants included members of the business office at A.B.C., physician partners, and the new C.E.O., who provided crucial assistance in understanding the practice history, the local market, the practice dynamics, and the core competencies and competitive advantages of the group. The research was performed through document analysis and literature review. After signing a privacy disclosure, the business office provided all requested financial documents for review. An examination of confidential documents, including productivity reports, billings and collections reports, patient metrics like patients per clinic, per-patient billing, durable medical equipment collections, PT referrals, ICD-10 coding benchmarks, and practice investments, a complete financial picture of the practice emerged. An extensive literature review of healthcare databases provided the primary context for the research regarding vertical integration. The participants requested that the study be completely blinded since the financial and organizational information is not available to the public.

## MARKET

As is the case in all medical practices in the U.S., the market is controlled by federal, state, and commercial payors who determine physician fee schedules through contractual arrangements (Centers for Medicare Services, 2022). Physicians have a limited capacity to negotiate a change in fee structure. Their prices, fees, and access are determined by insurance companies and the state and federal government. Medicare reimbursements are the starting point for all medical reimbursements (Centers for Medicare Services, 2022). Medicare determines rates based on relative value units (R.V.U.s), so ultimately, the federal government determines what physicians are paid in each geographic area. Every part of patient care is assigned a predetermined R.V.U. value and Medicare uses a conversion factor to consider local costs (Centers for Medicare Services, 2022). Medical practices succeed or fail based on the quality of patient care and efficiency of practice management.

A healthcare provider's business structure has myriad impacts on patient care. Sole provider and private group practices are becoming a rarity (American Medical Association, 2021; Capps et al., 2018; Fulton, 2017; Henry, 2019; LaPointe, 2019; Post et al., 2021). Many excellent sole providers, partnerships, and group practices have failed on the practice management portion and have thus folded and sold their practices to hospitals or hospital systems (Richards et al., 2022). Theoretically, hospital acquisition or vertical integration should provide economies of scale, increased communication between physician specialties, and improvement in the quality of patient care (Anonymous, 2014; Burns et al., 2014; Nikpay et al., 2018; Short et al., 2019). In practice, working for a hospital or hospital system provides stability and security for physicians but allows less autonomy over patient treatment decisions and increases physician burnout and a negligible improvement in quality of care (Bishop et al., 2016; Salvatore et al., 2018; Short et al., 2019). Between 2007-2017, hospital acquisition of private practice physician groups increased regardless of specialty, although surgical groups like A.B.C.

were acquired at a higher rate (Nikpay et al., 2018; Baker et al., 2014; Rademacher & Schafer, 2018; Richards et al., 2016). However, as the trend continues, there is increasing evidence that hospital integration increases patient costs with negligible effects on the quality of patient care (Amado et al., 2022; Baker, 2014; Berenson, 2017; Burns et al., 2013; Cooper et al., 2019; Curto et al., 2022; Fulton, 2017; Liebert, 2011; Neprash et al., 2015; Post et al., 2021; Richards et al., 2022).

In 2010, the Center for Studying Healthcare Change found that vertical integration can be utilized in processes that are detrimental to patients, for example, increased costs due to unnecessary bundling of physician and hospital services (Amado et al., 2022; Baker, 2014; Cooper et al., 2019; Curto et al., 2022; Richards, 2018; Short et al., 2020). A claims database review of patient claims in Massachusetts all payor claims database between 2009-2016 found that when physicians move from private practice to working for a hospital, they ordered 20% more unnecessary MRIs, usually done at the hospital where the physician was employed (Young et al., 2021). The Massachusetts claims study indicated that vertical integration decreased the value of patient care (Young, 2021). Another claims database review of 27.6% of commercially insured patients in the U.S. over a five-year period from 2007-2011 found that hospital prices for common procedures and tests varied 13-fold depending on the billing hospital; in markets with hospital monopoly, the prices were over 15% higher than similar markets with multiple hospital offerings (Cooper et al., 2019). A Medicare review of joint replacement surgery outcomes in 706 hospitals in 67 metropolitan markets found small and insignificant differences in quality between private and hospital-affiliated surgeons, yet 3.5-5.8% lower costs; the study did not qualify the costs reduction as a reduction of the expenses at the patient level or provider level (Machta et al., 2020). A 3-year Blue Cross Blue Shield commercial insurance database review found that per-patient spending by system-owned physicians was 5.8% higher; the increased spending was attributable to additional testing ordered and did not correlate with improved outcomes or quality (Ho et al., 2020b). When testing and procedures consistently cost more and are often erroneously ordered, the financial burden on our healthcare system without compensatory quality improvements is untenable (Short et al., 2020).

As inflation increases, the healthcare industry cannot effectively reduce operating costs compensatively due to large, fixed labor costs (Ford, 2022). Industries with high fixed labor costs are termed to suffer from “the cost disease,” a notion articulated by Baumol in 1993 when he described the situation where technological improvements, like electronic medical records, are insufficient to offset the increase in actual operating costs (Ford, 2022). Other industries with fixed labor costs can increase wages and salaries. Because state and federal governments determine healthcare reimbursements, physicians and other providers cannot directly increase their prices to compensate for inflation and demand for higher wages (Ford, 2022).

Hospitals can lock physicians into exclusivity contracts that prevent them from seeing patients at other hospitals, giving the hiring hospital a competitive advantage and allowing them another means to increase costs (Baker, 2014; Burns et al., 2014; Khuntia et al., 2022). Hospitals can also leverage their physician contracts to encourage the use of their testing facilities, pharmacies, surgery centers, and outpatient services (Baker, 2014). Change from physician-owned to hospital-owned often involves significant price increases to payors and patients and less personal service (Amado et al., 2022; Baker, 2014; Neprash, 2015; Whaley et al., 2021). For physicians, the difference usually has a minimal impact on compensation, yet for hospitals, it is exceptionally profitable (Baker, 2014; Gale, 2021; Neprash, 2015; Whaley et al., 2021a). Some private practices have sought private equity firms to provide a much-needed capital influx

beyond their capabilities as small businesses (Polsky, 2021). Concerns about the implications of hospital ownership on physicians' autonomy, compensation, and job satisfaction coupled with unrealized promises regarding improvements in patient outcomes and administrative efficiencies have influenced some physician-owned groups to seek outside capital without becoming vertically integrated with a hospital; other capital sources include health plans, venture capitalists, and large employers (Chu & Newman, 2020). Venture capitalists in the form of physician management companies can provide needed capital influx to struggling practices, yet, as with hospital acquisition, it comes at a price (Robeznieks, 2022). Physician management companies view medicine as any other for-profit enterprise; consequently, they focus on increasing cash inflow to the practice, not improving patient outcomes (Robeznieks, 2022). The American Hospital Association's 2020 market insights report noted that hospital-employed physicians' lack of autonomy related to clinical decision-making is a driving force behind the beginning of a new movement away from hospital acquisition towards partnerships with outside investors whose business model allows physicians to retain clinical autonomy (Chu & Newman, 2020). This movement is still in its beginning stages, and vertical integration with hospitals is still the most common ownership change for private practices.

## INDUSTRY

The local industry includes several key competitors, both privately owned and hospital-owned, as described in Table 1 (Appendix). The largest system-owned competitor is University Anystate Health, part of an extensive, state-wide health system with 30 local orthopedic providers practicing at multiple locations. The largest privately-owned competitor is Anytown Orthopedics, with over 40 physicians, mid-level providers, and numerous sites. An executive board runs them and is among the most well-known orthopedic groups in the metropolitan area. Anytown Orthopedics is run by an executive team and board of directors and is affiliated with several local sports teams.

## ORGANIZATIONAL HISTORY

ABC was formed in 2003 by the four founding partners, as indicated in Figure 1 (Appendix). These four doctors comprised a group that included one foot and ankle surgeon, one orthopedic surgeon, and two sports medicine physicians. They wanted to create a new physician-owned specialty practice in the Anytown area- one devoted primarily to treating athletes and sports-related injuries.

Two physicians were already acting as the Bucks team doctors when A.B.C. was formed. From 2005-2006 the group added three more partners. Later that year, along with other physician groups, they invested in and built an office complex to serve as a single building housing the Bucks training facility, the A.B.C. sports medicine practice, and numerous other medical specialties. Another partner was added in 2011, and together these seven physicians built a unique practice offering unparalleled medical care for athletes.

Their practice has served athletes of all types, from everyday athletes, weekend warriors, and junior and high school athletes to university-level and professional athletes. The practice evolved to treat acute athletic injuries and chronic problems created by overuse and offer injury prevention programs. Patients that require surgery can expect comprehensive follow-up care and physical therapy. A.B.C. had a PT division until 2018, when they partnered with Anytown

Physical Therapy, a state-wide physical therapy (PT) provider with multiple locations in Anytown and surrounding areas. This partnership turned A.B.C.'s PT from an expense to a significant revenue driver (A.B.C. partner physician, personal communication, March 15, 2021). Each A.B.C. office is housed adjacent to a PT center, allowing for communication between doctor and PT, enhancing patient outcomes. This partnership permitted A.B.C. to provide PT care at their practice locations, and numerous free-standing PT centers around the city and surrounding areas.

The practice expanded further by hiring three more physicians between 2014-2018, which improved patient access to primary sports medicine care. In 2018-2019 they added two more orthopedic surgeons. In 2021 A.B.C. added a seventh sports medicine doctor, an adult and pediatric orthopedic surgeon, and a spine surgeon (A.B.C. partner physician, personal communication, March 15, 2021).

A.B.C. has grown from its single initial location to include four other offices in Anytown and the surrounding areas. The COVID-19 pandemic brought telemedicine to the forefront of clinical care and added a new dimension to A.B.C.'s offerings, creating flexibility for follow-up care, especially for patients from other cities (A.B.C. partner, personal communication, March 15, 2021). Further expansion projects are underway, including investment in another office building and an additional practice location with PT and outpatient surgery services (A.B.C. business office, personal communication, March 15, 2021).

A.B.C. has several unique service offerings. Concussion screening for junior and high school athletes establishes a baseline brain scan for comparison in the event of future injuries. Physical therapy, provided through a partnership with Anytown Physical Therapy, is attached to every practice location. There are seven additional locations in and around the Anytown area (ABC PT, personal communication, March 15, 2021). This partnership allows them to provide cutting-edge physical therapy services to their patients during rehabilitation while maintaining open lines of communication between the physician, patient, and physical therapist. A.B.C. has also been the Anytown Bucks' team physician for over 20 years, and agreements were established and maintained based on exceptional care for the athletes (A.B.C. partner, personal communication, March 15, 2021).

## ISSUE

In the current healthcare environment in the U.S., is it practical and viable to continue to follow the private practice model when physician groups are increasingly hospital-owned? A Physicians Advocacy Institute and Avalere Health Analysis found that in the calendar year 2016 alone, hospitals acquired over 5,000 physician-owned practices, which was up 107% since 2012, and the scales tipped towards hospital-owned physician practices over private practice groups making 2016 the first year that more U.S. doctors were employees than business-owners (LaPointe, 2018; Owens, 2019). The vertical integration trend began around two decades ago and began a steady increase around 2009, and by the beginning of 2021, hospital ownership of physician practices was the norm, not the exception (Kocher et al., 2021; LaPointe, 2018; Muoio, 2021). As of 2022, 74% of all physicians in the U.S. were employed by a hospital or hospital system (Physicians Advocacy Institute, 2022).

Acquisitions are occurring at an ever-increasing rate, partly due to the excessive burdens placed on private practices due to the COVID-19 pandemic (Muoio, 2021). According to Medicare, the average reimbursement per R.V.U. (relative value unit) was $36.68 in 1998,

$36.03 in 2019, and $34.61 in 2022, representing a 5.66% actual pay decrease over 24 years (Cass, 2022; Coffron & Zlatos, 2019). For 2023, the Center for Medicare Services (CMS) decreased physician reimbursements to $33.06 per R.V.U., a $1.55 per R.V.U. decrease from the 2022 reimbursement amount (Centers for Medicare Services, 2022). Declining reimbursements are a reality in U.S. healthcare. This differential does not address inflation, which results in an effective pay decrease of 132% from 1998 to 2023, assuming typical inflation rates (Cass, 2022; Centers for Medicare Services, 2022).

The financial burden of malpractice insurance is onerous for private practice physicians. When a private practice includes surgeons, malpractice insurance is a more significant financial burden to the practice. Surgeons are considered one of three high-risk specialties (Nabity, 2020). The average U.S. physician pays $7,500 annually for malpractice coverage, while surgeons average $30,000- $50,000 annually (Nabity, 2020). When a private practice physician becomes employed by a hospital system, the hospital assumes the costs of malpractice insurance (Moses, 2018). Although acquiescing to a hospital buyout may seem to be the solution to the financial burdens imposed by decreasing reimbursements, overhead costs, reduced patient volume, staff shortages, and turnover, the impact of a hospital buyout on the overall healthcare marketplace has overwhelmingly been to increase prices (LaPointe, 2018; Owens, 2019; Madison, 2004; Muoio, 2021).

The problem of runaway healthcare costs in the U.S. seems to be analogous to the housing bubble of the 1990s, the telecommunication bubble of the early 2000s, and the current looming student loan bubble; the commonality here is the "bubble," and bubbles inevitably burst. The research indicates that the trend of hospitals acquiring physician practices is one side of the more significant issue of runaway healthcare costs that are rising at a level that is not sustainable (Ho et al., 2020). According to the AMA, as of mid-2019, the rate at which physicians were leaving private practice to work for hospital systems was slowing significantly; it is approximately 50% less than when physicians became hospital employees in the 1988-1994 timeframe (Henry, 2019). This study proposes that A.B.C. is not a practice clinging to an outdated operating model but instead ahead of the curve. If the hospital acquisitions continue at their current trajectory in tandem with rising healthcare costs, the pendulum could swing back over the next decade. If A.B.C. can weather and thrive in this storm, they could come out on the other side as owners of a strong, stable, and highly profitable practice in a future marketplace where physicians are breaking away from hospital employment and returning to private practices.

Despite the presence of this emerging hospital acquisition bubble, increasing overhead costs, decreasing reimbursements, and the challenges of running the complex business of private practice medicine have combined to push many groups to sell to hospital systems (LaPointe, 2019). A.B.C. will have to continue to overcome these issues while addressing the practice's future trajectory.

## PROBLEM

Did A.B.C. make the right decision to stay a private entity and decline the offer to sell to a hospital system? If so, how can they create a viable model for growing the practice, including how to add more partners and locations? What will the specific process be for adding more partners going forward? What will the process be for hiring more doctors or adding mid-level providers? How do they go about adding more locations? How do they effectively execute the

transition to an executive management team? All of these questions are under careful consideration and require prompt attention.

Over the past five years, two different hospitals have approached A.B.C. and expressed interest in buying or partnering with them. After weighing the pros and cons of each offer with respect to the impact on patient care, autonomy, compensation, and security, the partners decided to remain physician-owned. These decisions left A.B.C. in the minority of physician group practices in the U.S. The Avalere Physician Health and Advocacy Institute report that over the six-year period between 2012-2018 alone, group acquisition by hospitals, also known as vertical integration, grew 128% (LaPointe, 2019). Despite hospital claims that integration can reduce costs, improve the quality of care, increase efficiency, and effectively transition to value-based care models, increasing evidence points to a failure in many respects (Madison, 2004; Nikpay, 2018; LaPointe, 2019). A.B.C., like many physician-owned practices, is faced with declining reimbursements and increased practice management costs; thus, the allure of a fixed salary and benefits while handing off the daily stresses related to human resources and practice management to a hospital system sounds attractive to many groups (Coffron & Zlatos, 2019). Does leaving private practice to be employed by a hospital reduce the administrative burden? A national survey of 4720 physicians revealed that hospital-employed physicians spent more time on administrative tasks than self-employed physicians; however, hospital-employed physicians do not have practice management demands on their time (Woolhandler & Himmelstein, 2014). Hospital employment may reduce practice management time but increase other administrative time.

Firstly, the impact on patient care was considered. Multiple studies have concluded that hospital ownership of physician groups does not improve patient care but does increase costs (Ho et al., 2020a; LaPointe, 2019; Madison, 2004; Muoio, 2021). The patients at A.B.C. return when they have another injury and are apt to refer their friends and family members to the practice. They usually rate their doctors highly on social media and websites like Facebook, Google, and Healthgrades, as shown in Table A1. A.B.C. patients are generally pleased with the care that they receive. Patients are delighted to see the Bucks' doctors. The Bucks have chosen these physicians to be their doctors for over 20 years because they provide excellent care. Providing exceptional, innovative patient care and retaining autonomy over patient treatment decisions were instrumental components of the decision to remain physician-owned (A.B.C. partner, personal communication, March 15, 2021).

As a practice composed of physicians with over 15 years of experience in the private sector, A.B.C. considered autonomy or the loss thereof as a factor when contemplating a sale. The A.B.C. physicians can utilize their years of clinical experience, medical and surgical guidelines, standards of care, and innovative therapies, techniques, procedures, and surgeries to provide the care that each physician believes to be best for each patient. The A.B.C. doctors can offer newer treatments not covered by some insurance companies (A.B.C. partner, personal communication, March 15, 2021).

Although many younger doctors are leery of the risk of starting their own practice or buying into a group, choosing the security of a hospital contract may not be the stress-free path it appears to be (Owens, 2019). In 2011, a Mayo Clinic study cited levels of burnout among physicians at around 45%, which increased to 54% by 2014, coinciding with a substantial increase in physicians shifting to hospital employment instead of private practice (Owens, 2019). Another study from the British Medical Journal considered the impact of physician autonomy in the context of vertical integration; through insights gained from 220 physician questionnaires,

the researchers found that physicians are likelier to feel a stronger sense of identity with their hospital employer if they also enjoyed autonomous decision-making regarding their ability to organize their own work and to have an influence on organization-level decision-making (Salvatore et al., 2018). Burnout correlates with loss of autonomy when physicians become employees; doctors are trained to be decision-makers and bosses (Couser et al., 2022; Owens, 2019).

Physician compensation is an important variable for consideration when a group contemplates vertical integration. A.B.C. has four physician specialties: family practice sports medicine physicians, orthopedic surgeons, foot and ankle surgeons, and spine surgeons. Depending on the source, in 2022, the average annual pay for an orthopedic surgeon (including spine surgeons) was between $633,000-$750,000 (Katzowitz, 2022; Nazar, 2022). On average, sports medicine physicians were paid $187,000-$268,000, and podiatrists earned an average of $247,000, with the top earners at $731,000 (Katzowitz, 2022; Nazar, 2022). One large study that surveyed physicians between 2014-2018 found that physicians experienced a negligible financial impact after moving to work for a hospital system (Whaley et al., 2021). Given that A.B.C.'s partner physicians earn in the top 0.5% of their specialties, financial compensation was not a valid motivator to sell (A.B.C. partner, personal communication, March 15, 2021).

Long-term financial and job security was also a key aspect for contemplation when weighing the pros and cons of private practice ownership versus hospital employment. Job security is often a key selling point when a physician considers working for a hospital (LaPointe, 2019). Physicians are often guaranteed a salary for the first one to three years of employment. After that, financial compensation is usually tied to relative value units (R.V.U.s), the typical Medicare reimbursement model (Zigrang, 2022). The initial salary is generally quite attractive, but when doctors move to the RVU-based compensation model, they are usually unhappy with their declining salaries (Zigrang, 2022).

**DILEMMA**

ABC is at a critical juncture in its lifecycle: some of the founding partners are moving closer to readiness for reduced hours or retirement, there is intense competition in the local sports medicine market from both new and existing competitors, and the practice is losing its position as team doctors for the Bucks in 2024. A.B.C. transitioned to an executive management board in 2022 and is acclimating to the change. The practice is experiencing growing pains as it adds more partners and locations and hires more physicians. The partners must determine how to evolve into a practice with a hybrid management model and learn how to make decisions as a group of ten partners rather than the seven that have run A.B.C. for over a decade. They need to create a viable partnership track to add future partners. They must also create a plan to evolve into a practice run by the next generation of A.B.C. doctors as some partners move closer to retirement while the practice remains physician-owned.

Three of the seven founding partners are in their 60s, and the other four are in their 50s. They have reached a point where it is prudent to begin transparent discussions about future career plans, workloads, and paths to retirement. No formal discussions have occurred yet, and the topic remains in the background as the partners grapple with daily practice management.

A.B.C. is also staving off competition from both new and existing competitors. Anytown Orthopedics has taken over healthcare for a large local private university and the local professional baseball team and continues to try to make inroads in the care of the high school

football teams. The University of Anytown Medical will assume the title of the official healthcare provider for the Anytown Bucks in 2024. A.B.C. must aggressively capitalize on its position as team physician for the Bucks through typical marketing channels through the end of 2023. The practice has benefitted from its reputation as the Bucks' team physicians through its sideline presence at all televised games, word-of-mouth, and patients seeing the Bucks players in the clinics and the Anytown Athletics Complex building. Until 2022, A.B.C. did not formally use its relationship with the Bucks in its marketing campaigns. It is not yet quantifiable precisely what the fiscal impact will be when Anytown Medical physicians replace A.B.C. doctors courtside.

A.B.C. operated for 18 years with no executive board. The practice has grown to over 100 employees, and in 2022 practice management was turned over to the executive board. Since its inception, A.B.C. has been run by physician partners as an S Corporation (A.B.C. partner, personal communication, March 15, 2021). Their contract stipulated unanimity in voting decisions regarding expansion plans, investment, partnership issues, hiring additional physicians, and business partnerships (A.B.C. partner, personal communication, March 15, 2021). This unusual arrangement was successful for over 15 years. It became clear, especially as the partner group grew that a change had to be made as the current governing model was no longer viable. The partners each had busy practices operating at near capacity, and they no longer had the time or sufficient business expertise to continue to manage the practice as it grew.

The necessity of the executive board was crystallized when the practice added the latest three partners and hired additional employee physicians. The three newest partners were added quickly, and no formal partnership process was established before or since the expansion. (A.B.C. business office, personal communication, December 20, 2022). It is easier to make decisions with a small partnership committee, who have been colleagues for many years than to make consensus decisions with a large partnership committee, several of whom are new to both partnership and private practice.

The partners hired a C.E.O., selected the executive board, determined their pay structure, and established accountability. The partners had to decide which elements of practice management they wanted to retain control of and which needed to be handled impartially by the C.E.O. Now they need to adapt to less day-to-day control of practice management and maintain awareness of potential issues as the change in management structure is implemented. Previously the partnership board's managerial activities added an average of 20 hours of work per month for each partner (A.B.C. partner, personal communication, December 20, 2022). The business management side took an average of five hours a week per physician, with the additional time commitment required of those spearheading a specific organizational project. The recently hired human resources manager has mitigated this time demand, and the partners have allowed the C.E.O. to take control of more daily operational decisions. The executive board now runs cost analysis for staff per physician and is working to establish a dollar-per-hour allotment for each physician's staffing needs. When this is complete, the physicians would be free to give raises to their staff if they are under the allotment and hire an additional medical assistant or registered nurse. They can also hire a nurse practitioner, physician's assistant, or fellow paid for by the supervising physician. The new human resources manager is working on formal job descriptions and associated training for each position. They can also establish semi-annual performance reviews whereby staff knows how well they perform and what they need to do to get a raise. Currently, none of these things are in place.

## CORE COMPETENCY AND COMPETITIVE ADVANTAGES

A.B.C.'s core competency is consistent excellence in providing healthcare in sports medicine; all A.B.C. physicians are board-certified in their respective specialties and are also fellowship-trained (A.B.C. partner, personal communication, March 15, 2021). Not one of the competitor practices is solely composed of fellowship-trained physicians. Each A.B.C. physician was selected for their respective fellowship program, which speaks to the caliber of doctors in this practice. Every doctor who wants a fellowship cannot get one, and many doctors practice without board certification.

Patient access to physician care is a competitive advantage that allows the practice to provide rapid access to care currently unmatched by competitors. A.B.C. has a policy whereby all sports-related injuries, regardless of age, are seen within 24 hours, and all other patients are seen within 48 hours (A.B.C. partner, personal communication, March 15, 2021). Rapid patient access to care is another best practice that can be extremely difficult to duplicate without a flexible and efficient staff. The patient care coordinators all have company-provided mobile phones to receive texts and calls from patients and physicians; they quickly accommodate last-minute clinic additions without compromising care or patient time (A.B.C. partner, personal communication, March 15, 2021).

The second main competitive advantage is the unique relationship with the local Bucks franchise. Only one physician group can identify as being the team physician for the local professional team. This competitive advantage will only exist until 2023, so A.B.C. must maximize this relationship over the next year. A.B.C. physicians believe that the reputation that they have built supersedes any negative impact of ending their position as team doctors (A.B.C. partner, personal communication, December 20, 2022).

## BEST PRACTICES

ABC models several best practices that contribute to the success of its core competency and competitive advantages. The inherent value of the synergies between family medicine doctors and surgeons, the unique internal triage process, a democratic management style, and the option to have surgeries performed in an outpatient ambulatory surgery center are all highly effective components leading to the practice's success (A.B.C. partner, personal communication, March 15, 2021). The synergies between the different specialties demonstrate a culture analogous to the team culture of the Bucks in that it is team-focused (A.B.C. partner, personal communication, March 15, 2021). The internal triage process emphasizes the synergy created when sports medicine and surgeons work closely together (A.B.C. partner, personal communication, March 15, 2021). The democratic management style that has long been an asset had become a hindrance as the partnership team expanded from seven to ten physicians, necessitating the shift to management by the executive board (A.B.C. partner, personal communication, December 20, 2022). When hospitals acquire physician groups, costs to patients and payors increase significantly (Capps, 2018). Offering patients the opportunity to have their surgery in an outpatient setting provides substantial cost savings with comparable quality (Capps, 2018).

The synergistic culture involves hiring the right physicians who are either current or former athletes who love sports; these elements assist in empathizing with patients during treatment and recovery. The practice is not solely focused on orthopedics or sports medicine;

instead, it views sports medicine, foot and ankle surgery, and orthopedic surgery as integral components to complete patient care (A.B.C. partner, personal communication, March 15, 2021). Their culture celebrates each specialty's contributions to the practice, and the physicians embrace the belief that the whole is greater than the sum of its parts (A.B.C. partner, personal communication, March 15, 2021). Especially when hiring doctors whom might one day be partners, it is critical to hire physicians who will mesh well with the current practice culture and personalities (Collins & Porras, 2000). The practice looks at potential hires as people first and physicians second, which helps to maintain a culture that breeds trust and collective agreement.

The efficiency of internal triage is a brilliant example of the best practice in an effective process flow, as indicated in Figure 2 (Appendix). The structure of the patient triage process keeps all aspects of sports injury-related care in-house for seamless communication and treatment. The internal triage at A.B.C. enables surgeons to see surgical patients without wasting time seeing patients with a non-surgical diagnosis, as shown in Figure 2 (Appendix). The complete care continuum allows A.B.C. to care for their patients from diagnosis to x-ray and/or MRI, injections and durable medical equipment, surgery, follow-up, and physical therapy, all in-house (A.B.C. partner, personal communication, March 15, 2021). The greatest efficiency is in the sports medicine physicians' ability to pre-screen most potential surgical patients, avoiding the surgeons spending unnecessary clinic visits with non-surgical patients (A.B.C. partner, personal communication, March 15, 2021).

The physician specialties recognize that the constructive collaboration created by this process makes the practice more successful and allows each physician to earn a salary within the top .5% of their specialties across the U.S. (A.B.C. partner, personal communication, March 15, 2021; Nazar, 2022a; Nazar 2022b; Nazar, 2022c). The surgeons can do more surgeries because they see more surgical patients. Sports medicine physicians can yield better outcomes earlier because their patients are not needlessly seeing a surgeon first, only to be sent to a sports medicine physician for appropriate non-surgical care. Additionally, sports medicine doctors have ready access to orthopedic surgeons and foot and ankle surgeons should they ask a specific question about a complex patient. This capability decreases treatment time as the patient often does not need another appointment to have a second physician weigh in on their diagnosis.

Two key features differentiate A.B.C.'s patient triage from other models. Firstly, sports medicine doctors serve as screeners for surgeons (A.B.C. partner, personal communication, March 15, 2021). Second, the entire patient flow at A.B.C. is designed to be kept in-house. The typical patient flow at A.B.C. contrasts with that at a typical orthopedic practice, as indicated in Figures 2 and 3 (Appendix). A.B.C.'s patient flow results in better patient outcomes as patients are seen by the appropriate physician specialty sooner, resulting in a more rapid diagnosis. In-house testing means patients can have an X-ray or MRI the same day it is ordered instead of making an appointment at an imaging center. Integrated physical therapy indicates that patients can receive excellent PT services with therapists who are in regular communication with treating physicians resulting in seamless care coordination (A.B.C. partner, personal communication, March 15, 2021).

The democratic practice of governance is simultaneously a best practice and a potential future Achilles' heel. All partner physicians have equal voting rights regarding practice initiatives like expansion plans, hiring decisions, investment opportunities, and business partnerships (A.B.C. partner, personal communication, March 15, 2021). This method leads to successful brainstorming and a sense of equality and collaboration, often lacking in large group practices with dominant executive boards. The challenge will be effectively differentiating which

aspects of practice management are overdue for corporate oversight and which must be retained by the partners to avoid disrupting a high-performing culture.

## IMPLICATIONS

Several implications emerged as the practice reached its current size in 2022. These included the need for a professional management team or executive board to run the practice, a formal partnership track, and a clear path for partners seeking reduced hours or retirement (A.B.C. partner, personal communication, March 15, 2021). In continuing to grow the partnership board, hire more physicians, and add more locations, the practice has outgrown its current management structure (A.B.C. partner, personal communication, March 15, 2021). The addition of three new partners in early 2022 demonstrated that an objective path to partnership must be determined and abided by (A.B.C. partner, personal communication, December 20, 2022). As several of the founding partners age into their 60s, it is evident that specific processes must be established to allow partners to work reduced hours, sell their partnership to the remaining partners, and retire. If these developments do not occur, the potential fallout could include practice mismanagement, contention or even dissolution of the partnership, or conflict regarding the addition or retirement of a partner.

## LESSONS LEARNED

Key lessons learned from the development of the case study, which can help to shape future practice management and growth decisions, are based on two key areas: practice management and marketing. The partners learned that the practice management style of the partner physicians running the practice through weekly and ad hoc meetings and consensus building had reached the end of its viability (A.B.C. partner, personal communication, March 15, 2021). It was no longer an asset and had become a hindrance. The partners, especially the seven most tenured, relinquished some managerial control. Some growing pains have occurred as control was handed to the executive board. Still, the partners are aware that the new management structure will relieve the partners of the burdens associated with daily practice management demands like hiring employees, coordinating the repair of an X-ray or MRI machine, and deciding how and when to allocate pay raises (A.B.C. partner, personal communication, December 20, 2022).

With respect to marketing, given that A.B.C. will lose the official title of the Bucks' Team Physicians at the beginning of 2024, A.B.C. will have to determine how to mitigate any reputational fallout and proactively capitalize on the teams they continue to serve (A.B.C. partner, personal communication, December 20, 2022). Greater reliance on their outsourced internet marketing company will be necessary as the physicians expand newer services like telemedicine visits, second opinion virtual consults, and surgery-specific recovery videos featuring the surgeons talking to patients and continue to grow their ever-increasing social media presence (A.B.C. partner, personal communication, December 20, 2022). A.B.C. should reconsider the inclusion of "team doctor" in current marketing and capitalize on their existing relationships with high school and collegiate athletes, which are foundational elements of their core business.

## OPTIONS

ABC Sports Medicine is in the desirable position of having several viable options to address its practice and marketing issues. A.B.C. can still sell to a hospital system if the price is right and the partnership board decides it is in the practice's best interest. They also have cash on hand and cash flow that allows them to remain physician-owned and continue to expand in the number of practice locations and physicians (A.B.C. partner, personal communication, December 20, 2022). They have multiple options to augment existing marketing pieces: increase their social media presence, further develop their online video offerings for sports medicine and surgeons, and explore business partnerships that feature joint marketing efforts (A.B.C. partner, personal communication, December 20, 2022). Examples of increasing social media presence include Instagram uploads during sports events, Facebook check-ins, short videos detailing the physicians' engagement with athletes, and TikTok videos showing patient care clips (A.B.C. partner, personal communication, December 20, 2022). A.B.C.'s online video offerings currently include short videos posted to their website and Facebook that show an A.B.C. physician explaining a type of injury, care, and treatment for an injury or how to avoid it (A.B.C. partner, personal communication, December 20, 2022). These can be expanded to include preoperative and postoperative care videos and can be more consistent with regular postings so that patients can expect regular new content.

## RECOMMENDED FUTURE ACTIONS

The case concludes with two specific recommendations for continued success and improvement within the practice. Firstly, while hiring an executive management board was an excellent first step in addressing practice-management issues, the partners need to establish pathways for future organizational growth. A.B.C. needs to create a specific path to partnership. They must also clearly outline retirement options and agree upon avenues for reduced work hours and hiring mid-level practitioners and fellows. Addressing these issues will ensure that current partners can stay involved as the practice grows and evolves and avoid premature retirement and loss of valuable human capital.

The executive board must create and agree upon a partnership path. The path should include a timeline and trial period to demonstrate cohesion within the group. A formula for practice valuation needs to be agreed upon to effectively quantify the financial value of a partnership share in the future. Additionally, a path for hiring new employee physicians should be established. They need to decide the criteria within the practice that necessitates a new hire, who will conduct the hiring process, and the duration of employee-physician status prior to partnership offering.

A.B.C. needs to address the future of the older partners in the group. They have several very experienced and busy, more senior partners who might want to continue to practice but would like to be able to work in a reduced hours capacity. For example, overhead could be averaged for the year, and a physician could pay one-ninth of an overhead share per working month and then work for three months, then take one month off instead of paying one-twelfth of an overhead share every month. This would allow a physician to take a month off after three months of work without an excessive overhead burden to be paid when they are off. Another option would be to offer a job share opportunity. This might entail two physicians sharing clinic overhead and splitting one share of ancillary income. The job-sharing doctors could each work

2.5 days per week, alternating two days and three days, or work out any arrangement that yielded 50/50 work. This arrangement might allow the practice to attract physicians with young children who want to work part-time or older physicians closer to retirement.

Second, they must address the changes to their relationship with the Bucks and attempt to quantify the business impact of losing that relationship while mitigating it through alternative marketing channels. A.B.C. needs to work with its marketing team to enact new avenues for patient contact and visibility, as their lack of presence at the professional games in 2024 will be noticed. Enhancing its presence on social media platforms and growing its virtual offerings like telemedicine and video-based patient educational content are viable avenues to maintain patient contact and increase visibility. Through an effective transition to a professional management structure and emphasis on marketing innovations, A.B.C. can address current managerial challenges and stay profitable as the group grows.

## RESULTS

The research sought to answer the question: Can a private physician-owned specialty practice stave off hospital acquisition and successfully provide physicians with quality patient care and above-average profits? When a hospital or hospital system buys a private specialty physician practice, are physicians and patients affected? And can a private practice stay private, grow, and thrive in the highly regulated healthcare industry in the U.S.?

Avoiding hospital acquisition and thriving as a private practice while providing excellent patient outcomes is possible. Physicians can not only make above-average profits, but they can also achieve pay commensurate with the top echelon of their respective specialties. As physician reimbursements continue to decline, effective management and marketing are essential to continue receiving top-tier compensation. Physicians and patients are impacted when vertical integration occurs. Patient quality of care can decline while their costs increase. Physicians experience less job satisfaction through loss of autonomy and the ability to share significant income growth. Private practices can stay physician-owned, grow, and flourish in the U.S. healthcare market.

The methodology for this qualitative instrumental case study involved private document analysis and an in-depth literature review in developing a more comprehensive understanding of the reasons behind A.B.C. Sports Medicine's ability to stay privately owned, grow, and even thrive in a healthcare environment dominated by increasing hospital-acquisition of physician groups. The document review supported the conclusion that A.B.C. is flourishing, growing, and achieving excellent patient outcomes. The literature review indicated that although vertical integration of private practices with hospitals and hospital systems is still a growing trend, the growth rate is declining, and vertical integration has not yielded the expected outcomes of improved economies of scale, a better quality of patient care, and reduced costs (Baker, 2014; Berenson, 2017; Fulton, 2015; Henry, 2019; Neprash et al., 2015). The study demonstrated that private practice can grow and thrive in the current U.S. healthcare marketplace.

A review of A.B.C.'s private documents and a literature review on vertical integration of private practices and hospital systems provided several key understandings. The confidential document review uncovered that A.B.C.'s physicians received a salary in the top .5% of their respective specialties (Nazar, 2022a; Nazar, 2022b; Nazar, 2022c). This is especially unusual since the practice has both primary care physicians and specialists. Although most physician visits in the U.S. are with primary care physicians, 60% of all active physicians are specialists,

and the current health policies and healthcare environment in the U.S. disproportionately support healthcare spending with specialists (Ellis et al., 2018). Practice growth was shown through the increase in partnership from four to twelve partners, the hiring of additional physicians, and the addition of four more practice locations. Excellence in patient outcomes was demonstrated through analysis of over 1200 patient reviews from five review sites, Facebook, A.B.C.'s website, Healthgrades, Google, and Birdseye, yielding a weighted average review score of 4.45/5.0 as indicated in Table 2 (Appendix).

The published literature related to vertical integration in the U.S.. is extensive. The initial expectations of increased economies of scale, improved patient outcomes, enhanced communication between physician specialties, and lower costs have not materialized (Baker, 2014; Berenson, 2017; Burns et al., 2014; Fulton, 2015; Henry, 2019; Neprash et al., 2015; Nikpay et al., 2018). Although literature indicated that vertical integration of private practices with hospitals and hospital systems is still a growing trend, the growth rate is declining, and vertical integration has yielded an increase in physician burnout, increased costs to patients and payors, and no demonstrable improvement in the quality of patient care (Baker, 2014; Berenson, 2017; Couser et al., 2022; Fulton, 2015; Henry, 2019; Neprash et al., 2015). Now that vertical integration has been a part of the U.S. healthcare market for two decades, there is ample evidence as to the impact that it has had on patient and payor costs, quality of care, and physician compensation. Increasingly the evidence supports private practice ownership and does not find that vertical integration has resulted in the expected cost and quality improvements. Healthcare services, including imaging and laboratory tests provided by hospital-employed physicians, cost 14.1% more than private practice physicians (Capps et al., 2018; Whaley et al., 2021b). (Capps et al., 2018). Increasing costs without a commensurate improvement in outcomes is an unsustainable model. In 2013 a comprehensive review of the economies of scale created through vertical integration found that the expected efficiencies were not realized, and integration posed anti-competitive threats due to the expectation that hospital-employed physicians would order tests and perform procedures and surgeries at their parent hospital (Baker et al., 2014). Why does the vertical integration trend continue if these concerns have been so readily apparent for at least ten years?

## FUTURE RESEARCH

Further research is needed in this field on qualitative and quantitative outcomes related to vertical integration compared to maintaining physician-owned private practices. This could be accomplished with multiple study designs. For example, a phenomenological study of several physician-owned private practices could highlight competitive advantages and best practices that could be duplicated in other practices; this method could provide insights into the physician-owner mindset. Older research had suggested a positive relationship between integrated delivery systems and improvements in outcomes, yet as the volume of research increases and data on outcomes related to vertical integration becomes more readily available, a definitive judgment on the failure of hospital integration to achieve its expected results is increasingly likely (Leibert, 2011). For more generalizable research, large-scale surveys could ascertain compensation, job satisfaction, autonomy, and management styles of private practices in the U.S. compared to hospital-employed physicians. As more extensive research is conducted, ignoring the detrimental effects on patients and physicians in the U.S. healthcare system is becoming increasingly difficult.

The American Medical Association's White Paper summarizing the research from interviews with the lead physicians from 25 successful privately-owned medical practices found that while system-owned practices are now the majority, private practices are still essential contributors whose outcomes meet and exceed those in hospital-owned practices (Rittenhouse, 2021). The AMA White Paper should serve as a model for future research on successful private practices.

## DISCUSSION

We propose that this qualitative instrumental case study has several meaningful findings for the field. This case demonstrated that A.B.C. physicians did their due diligence in considering both the short and long-term effects of acquiescence to a vertical integration proposal. It is far easier to have a practice acquired by a hospital system than to restart a private group practice after a hospital employs it. Private ownership has benefits, including autonomy and greater potential profitability, and downsides, including managerial burden and greater financial risk. A.B.C. assumed the financial risk and administrative responsibility and achieved better patient outcomes and profitability. A.B.C. has remained successful by capitalizing on the inherent value of the synergies between the medical specialties, the democratic management style, and community connection through relationships with local professional, collegiate, and high school sports teams.

The temptation to sell a private practice to a hospital stems from the issues facing physician owners in the U.S. healthcare marketplace. Increasing overhead costs, declining reimbursements, daily practice management challenges, and human resource issues are all considerations when contemplating selling to a hospital system. It is equally important to consider the impact on the autonomy of care, the long-term impact of a sale, and the implications for patients and physician profit (Baker, 2014; Berenson, 2017; Fulton, 2015; Henry, 2019; Neprash et al., 2015; Physicians Advocacy Institute, 2022).

This case study of A.B.C. Sports Medicine shows that a private physician-owned specialty practice can stave off hospital acquisition and successfully provide physician-owners quality patient care and above-average profits. Research indicates that physicians and patients are affected when a hospital or hospital system buys a private specialty physician practice; physician autonomy decreases, burnout increases, and compensation often declines (Berenson, 2019;Bishop, et al., 2016; Katzowitz, 2022; Nikpay, et al., 2018; Salvatore, et al., 2018). Physicians in the U.S. are starting to become aware of the detrimental effects of vertical integration.

The problem of runaway healthcare costs in the U.S. is a bubble analogous to the housing bubble of the 1990s, the telecommunication bubble of the early 2000s, and the current looming student loan bubble; the commonality here is the "bubble," and bubbles inevitably burst. The trend of hospitals acquiring physician practices is one side of the more significant issue of runaway healthcare costs rising at a level that consistently outpaces inflation (Ho et al., 2020a). Medicare is charged double the price for the same procedure done by a system-owned physician versus that in a private physician's office (Gale, 2021). If hospital acquisitions continue at their current trajectory in tandem with increasing healthcare costs, the pendulum could swing back over the next decade. Data from the AMA in 2019 suggests that the rate at which physicians leave private practice to work for hospital systems is slowing significantly; this might be an early indicator that physicians recognize the downside to hospital ownership (Henry, 2019; Physicians

Advocacy Institute, 2022). An empirical review of the effects of vertical integration on costs and quality of care raises concerns about antitrust issues, healthcare affordability, and existing government healthcare policies (Greaney, 2021; Post et al., 2017). This research proposes that A.B.C. is not a practice clinging to an outdated operating model but is instead ahead of the curve. A change in healthcare policy could radically change the playing field if legislation no longer supports vertical integration (Cirruzzo, 2020). If antitrust concerns resulted in lawsuits, the entire delivery system could implode. By addressing the issues with the outdated practice model, shifting marketing emphasis as their relationship with the local professional sports team ends, and enacting partnership and retirement paths for the next evolution of the practice, A.B.C. can weather and thrive in the vertical integration storm. They can come out on the other side as owners of a strong, stable, and highly profitable practice in a future marketplace where physicians are breaking away from hospital employment and heading back to private practices.

**REFERENCES**

Amado, G., Ferreira, D., & Nunes, A. (2022). Vertical integration in healthcare: What does literature say about improvements on quality, access, efficiency, and costs containment? *The International Journal of Health Planning and Management.* 37(3), 1252-1298. https://doi.org/10.1002/hpm.3407

American Medical Association. (2021, May 5). *AMA. analysis shows most physicians work outside private practice* [Press release]. *American Medical Association.* https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice

Anonymous. (2014) acquisition and affiliation strategies highlights from HFMA's Value Project research. (2014). *Healthcare Financial Management, 68*(8), 70-3. https://uiwtx.idm.oclc.org/login?url=https://www.proquest.com/trade-journals/acquisition-affiliation-strategies-highlights/docview/1555372418/se-2

Baker, L., Bundorf, M., & Kessler, D. (2014). Vertical integration: Hospital ownership of physician practices is associated with higher prices and spending. *Health Affairs,* 33(5), 756-763. https://uiwtx.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/vertical-integration-hospital-ownership-physician/docview/1525958722/se-2

Berenson, R. (2017). A physician's perspective on vertical integration. *Health Affairs,* 36(9), 1585-1590. https://doi.org/10.1377/hlthaff.2017.0848

Bishop, T., Shortell, S., Ramsay, P., Copeland, K., & Casalino, L. (2016). Trends in hospital-ownership of physician practices and the effect on processes to improve quality. *American Journal of Managed Care,* 22(3), 172-176. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4831046/pdf/nihms774621.pdf

Burns, L., Goldsmith, J., & Sen, A. (2014). Horizontal and vertical integration of physicians: a tale of two tails. *Advances in Health Care Management*, (15)39–117. https://doi.org/10.1108/s1474-8231(2013)0000015009

Capps, C., Dranove, D., & Ody, C. (2018). The effect of hospital acquisitions of physician practices on prices and spending. *Journal of Health Economics*, (59)139–152. https://doi.org/10.1016/j.jhealeco.2018.04.001

Cass, A. (2022). CMS .CMS pitches physician payment rule for 2023: 7 things to know. *Becker's Hospital Review.* https://www.beckershospitalreview.com/finance/cms-pitches-physician-payment-rule-for-2023-7-things-to-know.html

Centers for Medicare Services (2022). Calendar Year C.Y.Y. 2023 Medicare Physician Fee Schedule Final Rule. *Center for Medicare Services.* https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule

Chu, B. & Newman, N. (2020). Evolving physician-practice ownership models-market insights report. *American Hospital Association.* https://www.aha.org/system/files/media/file/2020/02/Market_Insights_MD_Ownership_Models.pdf

Cirruzzo, C. (2020). FTC. FTC Says It Is Cracking Down On Anti-Competitive Hospital Behavior. *InsideHealthPolicy.Com's Inside Health Reform, 12*(4) https://uiwtx.idm.oclc.org/login?url=https://www.proquest.com/trade-journals/ftc-says-is-cracking-down-on-anti-competitive/docview/2343005518/se-2

Coffron, M., & Zlatos, C. (2019). Medicare physician payment on the decline: it's not your imagination. *Bulletin of the American College of Surgeons.* https://bulletin.facs.org/2019/09/medicare-physician-payment-on-the-decline-its-not-your-imagination/

Collins, J. & Porras, J. (2000). Building Your Company's Vision. *Harvard Business Review.* https://hbr.org

Cooper, Z., Craig, S., Gaynor, M., Van Reenen, J. (2019). The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics* 134(1):51–107. https://doi.org/10.1093/qje/qjy020

Couser, G., Morrison, D., & Brown, A. (2022). Getting Serious About People Over Profit: Addressing Burnout by Establishing Meaning and Connection. *Physician Leadership Journal, 9*(4), 29-35. https://uiwtx.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/getting-serious-about-people-over-profit/docview/2702265942/se-2

Curto, V., Sinaiko, A., & Rosenthal, M.(2022). Price Effects of Vertical Integration and Joint Contracting Between Physicians and Hospitals in Massachusetts. *Health Affairs, 41*(5), 741-29. https://uiwtx.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/price-effects-vertical-integration-joint/docview/2659304408/se-2

Ellis, S., Karim, S., Vukas, R., Marx, D., & Uddin, J. (2018). Four Needles in a Haystack: A Systematic Review Assessing Quality of Health Care in Specialty Practice by Practice Type: *The Journal of Health Care Organization, Provision, and Financing. Inquiry,* 55 https://www.proquest.com/healthmanagement/docview/2186161681/fulltextPDF/B3A09AD8A7754BFFPQ/8?accountid=7139

Ford, E. W. (2022). There Has Been an Outbreak of "Cost Disease": Are Hospitals Ready? *Journal of Healthcare Management, 67*(3), 137-139. https://doi.org/10.1097/JHM-D-22-00074

*Health Affairs,36*(9), 1530-1538. https://doi.org/10.1377/hlthaff.2017.0556

Fulton, B. (2017). Health Care Market Concentration Trends in The United States: Evidence And Policy Responses. *Health Affairs, 36*(9), 1530-1538. https://doi.org/10.1377/hlthaff.2017.0556

Gale, A. (2021). Hospitals' Opposition to Site Neutral Payments Prove They Are More Interested in Profiting from Owning Doctors than in Lowering Health Care Costs. *Missouri Medicine, 118*(2), 94-96. https://uiwtx.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/hospitals-opposition-site-neutral-payments-prove/docview/2745076071/se-2

Greaney, T. (2021). The New Health Care Merger Wave: Does the "Vertical Good" Maxim Apply? *Cambridge University Press.* https://www.cambridge.org/core/journals/journal-of-law-medicine-and-ethics/article/abs/new-health-care-merger-wave-does-the-vertical-good-maxim-apply/D526914176D2AE1E6FA88DEAD857EC48

Henry, T. (2019). Employed physicians now exceed those who own their practices. *AMA* https://www.ama-assn.org/about/research/employed-physicians-now-exceed-those-who-own-their-practices

Ho, V., Metcalfe, L., Lan, V., Marah, S., & Morrow, R. (2020a). Annual spending per patient and quality in hospital-owned versus physician-owned organizations: an observational study. *Journal of General Internal Medicine, 35*(3), 649-655. https://doi.org/10.1007/s11606-019-05312-z

Ho, V., Sasathorn, T., Metcalfe, L., Lan, V., & Marah, S. (2020b). Using Medicare data to measure vertical integration of hospitals and physicians. *Health Services & Outcomes Research Methodology, 20*(1), 1-12. https://doi.org/10.1007/s10742-020-00207-7

Katzowitz, J. (2022). How much money do doctors make a year? Doctor salary by specialty. *The White Coat Investor.* https://www.whitecoatinvestor.com/how-much-do-doctors-make/

Khuntia, J., Ning, X., & Stacey, R. (2022). Competition and Integration oU.S.US Health Systems in the Post-COVID-19 New Normal: Cross-sectional Survey. *JMIR Formative Research, 6*(3)https://doi.org/10.2196/32477

Kocher, R., Shah, S., & Navathe, Amol, S. (2021). Overcoming the Market Dominance of Hospitals: The Journal of the American Medical Association. *Jama, 325*(10), 929. https://doi.org/10.1001/jama.2021.0079

LaPointe, J. (2019). Hospital acquisitions of physician practices rose 128% since 2012. *Practice Management News.* https://revcycleintelligence.com/news/hospital-acquisitions-of-physician-practices-rose-128-since-2012

Leibert, M. (2011). Performance of integrated delivery systems: quality, service and cost implications. *Leadership in Health Services, 24*(3), 196-206. https://doi.org/10.1108/17511871111151108

Madison K. (2004). Hospital-physician affiliations and patient treatments, expenditures, and outcomes. *Health Services Research*, *39*(2), 257–278. https://doi.org/10.1111/j.1475-6773.2004.00227

Machta, R., Reschovsky, J., Jones, D., Furukawa, M., & Rich, E.(2020). Can vertically integrated health systems provide greater value: The case of hospitals under the comprehensive care for joint replacement model? *Health Services Research, 55*(4), 541-547. https://doi.org/10.1111/1475-6773.13313

Moses, E. (2018). Understanding Malpractice Insurance. *Association for Advancing Physician and Provider Recruitment.* https://physiciansthrive.com/malpractice-insurance/costs/

Muoio, D. (2021). Hospitals, corporations own nearly half of medical practices, spurred by COVID-19 disruption: report. *Fierce Healthcare.* https://www.fiercehealthcare.com/practices/practice-consolidation-private-practice-departures-skyrocketed-during-covid-19

Nabity, J. (2020). How Much Does Medical Malpractice Insurance Cost? *Physicians Thrive.* https://physiciansthrive.com/malpractice-insurance/costs/

Nazar, J. (2022a) Foot & Ankle Surgeon Salary. *Comparably.* https://www.comparably.com/salaries/salaries-for-foot-and-ankle-surgeon

Nazar, J. (2022b) Physician, primary care sports medicine salary. *Comparably.* https://www.comparably.com/salaries/salaries-for-physician-primary-care-sports-medicine

Nazar, J. (2022c) Orthopedic surgeon salary *Comparably.* https://www.comparably.com/salaries/salaries-for-orthopedic-surgeon

Neprash, H., Chernew, M., Hicks, A., Gibson, T., McWilliams, J. (2015) Association of financial integration between physicians and hospitals with commercial health care prices. *JAMA Internal Medicine.* https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2463591

Nikpay, S., Richards, M., & Penson, D. (2018). DATAWATCH: Hospital-physician consolidation accelerated in the past decade in cardiology, oncology. *Health Affairs, 37*(7), 1123-1127, 1127A-1127E. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1520

Owens, B. (2019). Work–life advantages of becoming a salaried physician may be oversold. *Canadian Medical Association Journal, 191*(4), E113-E114. https://doi.org/10.1503/cmaj.109-5699

Physicians Advocacy Institute (2022). COVID-19's Impact on Acquisition of Physician Practices and Physician Employment 2019-2022. *Avalere Health.* http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d

Polsky, D. (2021). Private equity and physician medical practices- Navigating a changing ecosystem. *The New England Journal of Medicine, 84*(11), 981-983. https://doi.org/10.1056/NEJMp2032115

Post, B., Buchmueller, T., Ryan, A. (2018) Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality. *Medical Care Research and Review.* 75(4):399-433. https://doi.org/10.1177/1077558717727834

Post, B., Norton, E., Hollenbeck, B., Buchmueller, T., & Ryan, A. (2021). Hospital-physician integration and Medicare's site-based outpatient payments. *Health Services Research*, *56*(1), 7+. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7839648/

Rademacher, K., & Schafer, J. (2018). The Total Care Package. *Pharmaceutical Executive, 38*(5), 40-41. https://uiwtx.idm.oclc.org/login?url=https://www.proquest.com/trade-journals/total-care-package/docview/2056028064/se-2

Richards, M., Nikpay, S., & Graves, J. (2016). The Growing Integration of Physician Practices: With a Medicaid Side Effect. *Medical Care, 54*(7), 714. https://uiwtx.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/growing-integration-physician-practices-with/docview/1799372340/se-2

Richards, M., Seward, J., & Whaley, C. (2022). Treatment consolidation after vertical integration: Evidence from outpatient procedure markets. *Journal of Health Economics, 81*, 1. https://doi.org/10.1016/j.jhealeco.2021.102569

Richards, M., Smith, C., Graves, A., Buntin, M., & Resnick, M. (2018). Physician Competition in the Era of Accountable Care Organizations. *Health Services Research, 53*(2), 1272-1285. https://doi.org/10.1111/1475-6773.12690

Rittenhouse, D. et al. (2021). Supporting and Promoting High-Performing Physician-Owned Private Practices: Voices from the Front Lines. *American Medical Association.* https://www.ama-assn.org/system/files/mathematica-ama-white-paper.pdf

Robeznieckс, A. (2022). Physicians warned of the pitfalls of private equity promises. *American Medical Association.* https://www.ama-assn.org/practice-management/private-practices/physicians-warned-pitfalls-behind-private-equity-promises

Salvatore, D., Numerato, D., & Fattore, G. (2018). Physicians' professional autonomy and their organizational identification with their hospital. *B.M.C. Health Services Research, 18.* https://doi.org/10.1186/s12913-018-3582-z

Short, M., & Ho, V. (2020). Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality. *Medical Care Research and Review: MCRR, 77*(6), 538-548. https://doi.org/10.1177/1077558719828938

Whaley, C., Arnold, D., Gross, N., & Jena, A. (2021a). Physician compensation in physician-owned and hospital-owned practices. *Health Affairs,40*(12), 1865-24. https://doi.org/10.1377/hlthaff.2021.01007

Whaley, C., Zhao, X., Richards, M., & Damberg, C. (2021b). Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration. *Health Affairs, 40*(5), 702-709,1A-19A. https://doi.org/10.1377/hlthaff.2020.01006

Woolhandler, S. & Himmelstein, D. (2014). Administrative work consumes one-sixth of U.S. physicians' hours and lowers their career satisfaction. *International Journal of Health Services.* https://journals.sagepub.com/doi/10.2190/HS.44.4.a

Young, G., Zepeda, E., Flaherty, S., & Thai, N. (2021). Hospital Employment of Physicians in Massachusetts Is Associated with Inappropriate Diagnostic Imaging. *Health Affairs,40*(5), 710-718,1A-7A. https://doi.org/10.1377/hlthaff.2020.01183

Zigrang, T. (2022). Healthcare compensation plans: Current challenges and novel approaches. *Frontiers of Health Services Management, 8*(4), 26-32. https://doi.org/10.1097/HAP.0000000000000141

## APPENDIX

Figure 1

Timeline of A.B.C. Sports Medicine 2003-Present

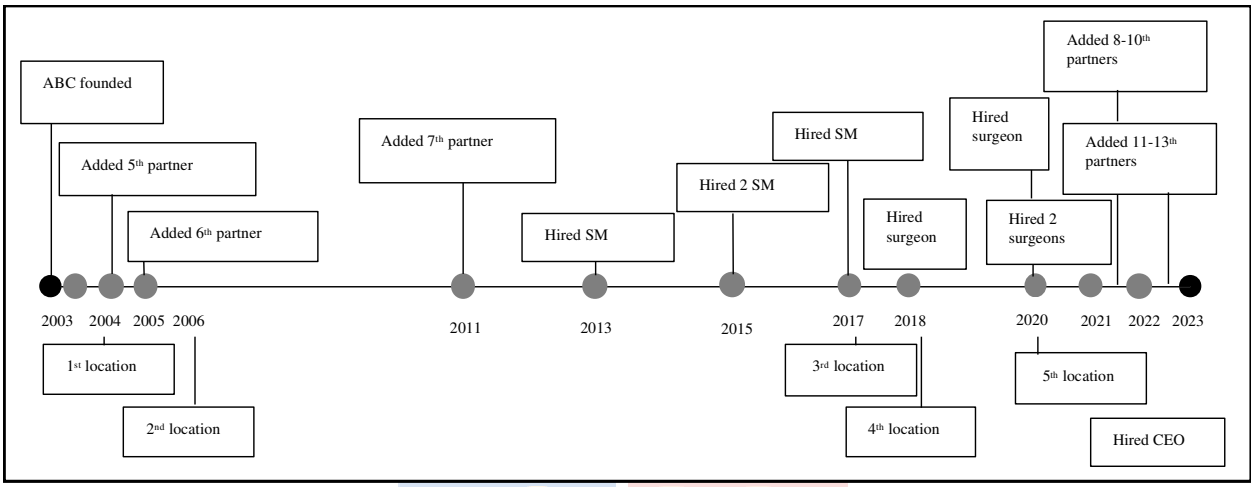
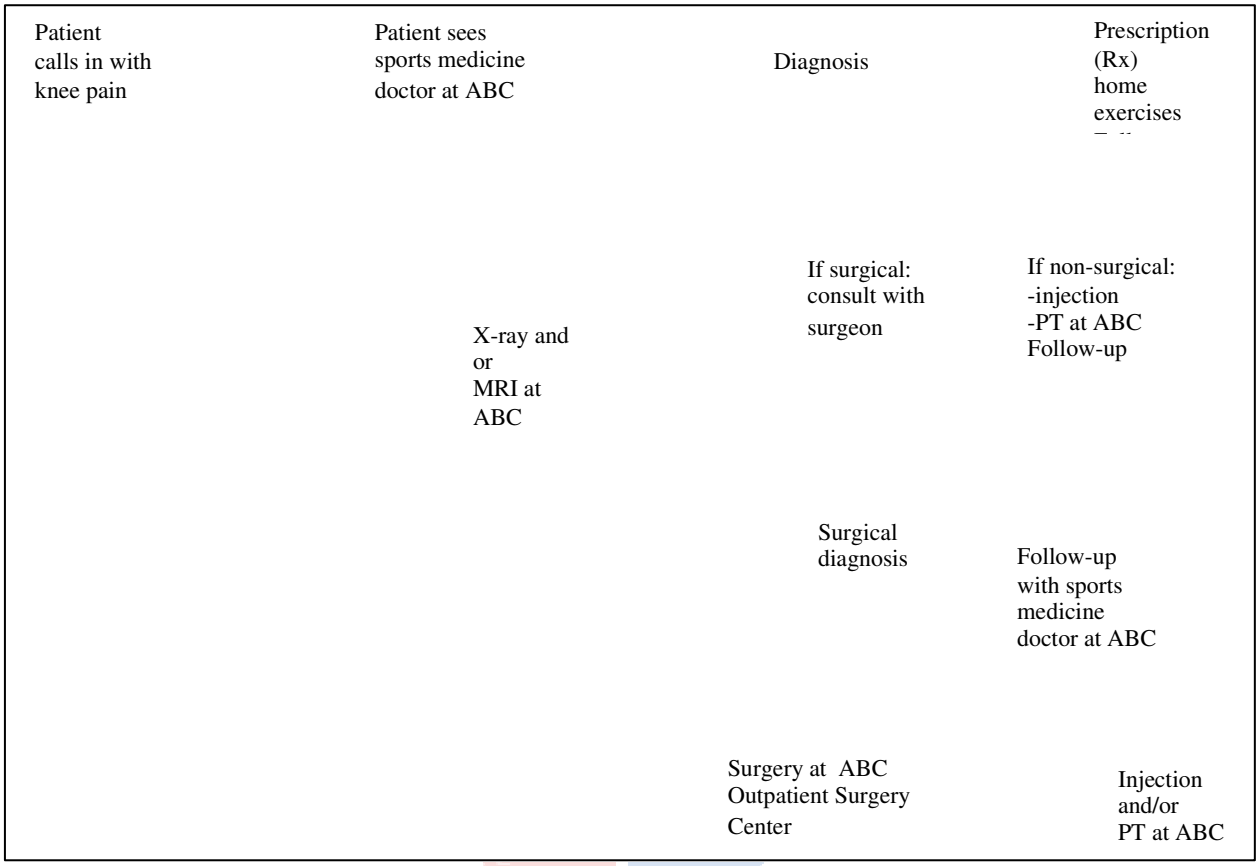


Figure 2

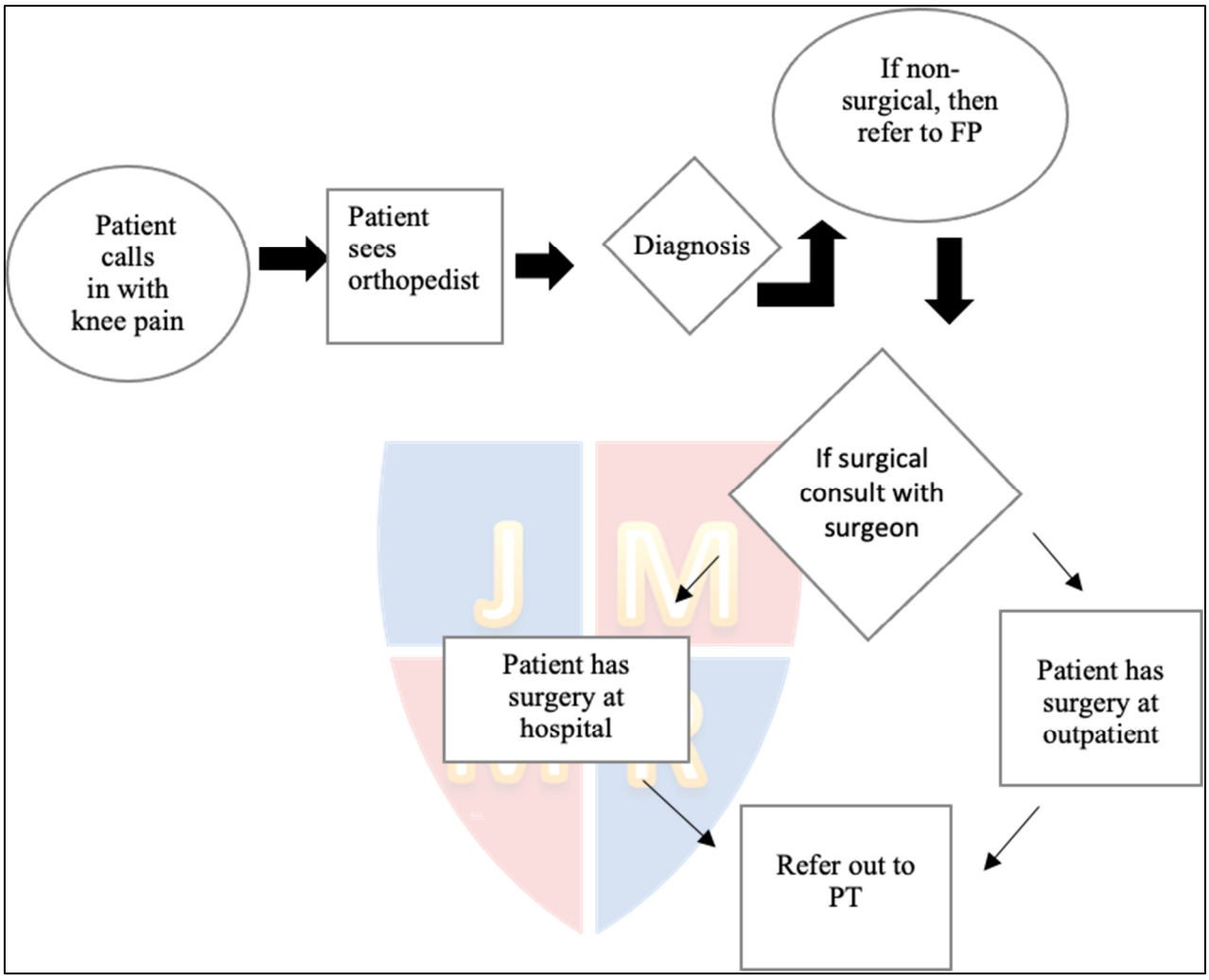
*A.B.C. Sports Medicine Typical Treatment Flow for Knee Pain Patient*




*Note*: The treatment flow diagrams above outline A.B.C.'s patient triage process.

Figure 3

*Treatment Flow in a Typical Orthopedic Practice for a Knee Pain Patient*




*Note*: The above treatment flow outlines the patient flow of the typical orthopedic practice where sports medicine physicians and physical therapists are not a component of the practice.

Table 1

*Comparison of Local Orthopedic and Sports Medicine Practices*

| Practice Name | Providers | Locations | PT | MRI | DME | Primary care & specialty | Offer telemedicine | Saturday Sports Clinic | Ownership |
|---|---|---|---|---|---|---|---|---|---|
| ABC | 15 | 7 | Yes | Yes | Yes | Yes | Yes | Yes | Private |
| Anytown Sports & Occupational Surgery | 2 | 2 | No | No | No | No | No | No | Private |
| University | 28 | 6 | No | Yes | No | No | No | No | Hospital |
| University Anystate Health | 35 | 3 | No | Yes | No | Yes | No | No | Hospital |
| Alpha | 1 | 4 | No | Yes | No | Yes | No | Yes | Hospital |
| Beta | 11 | 5 | No | Yes | No | No | No | No | Hospital |
| Comprehensive Orthopaedics | 7 | 3 | Yes | No | Yes | Yes | No | No | Private |
| Church | 12 | 9 | No | Yes | No | No | No | No | Hospital |
| Anytown Orthopaedics | 42 | 8 | Yes | Yes | No | Yes | No | No | Private |

*Note: PT is physical therapy; MRI is magnetic resonance imaging; D.M.E. is durable medical equipment;*

Table 2

*Sample of Representative Patient Reviews of A.B.C. Sports Medicine*

| Patient Reviews | | | |
|---|---|---|---|
| Patient review source | Number of reviews | Average ranking (5-point scale) | Representative quotes |
| Facebook | 267 | 4.7 | All the doctors are amazing. |
| | | | I am thankful for the partnership with our high schools and for providing our young athletes with amazing care |
| | | | I have been a patient for 12 years and have seen three different doctors at A.B.C. for various issues. My care has always been outstanding, and I would not hesitate to recommend it to anyone seeking orthopedic care. |
| Google | 199 | 4 | Love the staff and doctors! |
| | | | Dr. S is very attentive, communicates well, and explains the reasoning and actions. Dr. S has an amazing ability to bond with patients. I 100% recommend Dr. S.! |
| | | | My daughter's 2-year shoulder pain disappeared under Dr. M's care. |
| Healthgrades | 242 | 4.5 | More convenient because they can do everything in one location. |
| | | | Two surgeries with Dr., and they went perfectly with easy recovery. |
| | | | Fantastic doctor! |
| | | | He explained everything very well. I would definitely recommend him. |
| A.B.C. practice website | 192 | 4.1 | They are the best group in town! |
| | | | Amazing care! One of the best surgeons that I have been to! |
| | | | I switched to Dr. G to have my hip replaced, and it was the best decision I ever made. |
| Birdseye | 495 | 4.3 | Dr. S and his staff are great, very caring, and professional. |
| | | | The quality of care is amazing, as is their customer service! |
| | | | A.B.C. is the best! |