Saving Private Practice: Size and Sustainability in the 21st Century

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INTRODUCTION: CHANGES IN THE SIZE AND NATURE OF PRIVATE PRACTICE OVER TIME

The landscape of US radiology has changed substantially in just a few decades. One of the most profound changes is in the size of private practice groups. Sunshine and Bansal [1] reported that in 1989, "almost half of U.S. radiology groups had two to four radiologists, almost one-fourth had five to seven radiologists, 12% had eight to 10 radiologists, and 14% had 11 or more." The authors further noted that this had been stable since 1986. Fast-forwarding to the past decade, the picture was substantially different in 2014. At that time, only 3.2% of US groups had one or two members, 15.7% of groups had more than 100 radiologists, and there was a category for groups of more than 500 [2]. In that same report, the authors noted significant shifts of radiologists from smaller to larger groups from 2014 to 2018, with a concomitant reduction in the number of private groups in the United States in both multispecialty and single-specialty categories.

As practices grow in size, they increasingly develop more organized and usually more corporatized structures. Concomitant with that have been the appearance and growth of for-profit, third-party-financed (private equity and venture capital) corporations that are consolidating radiology groups. This increase in size and change in employment models raises questions about the sustainability of the private practice model in the United States in the 2020, especially in the face of challenges such as the coronavirus disease 2019 pandemic, declining reimbursement, and increasing regulation.

ENVIRONMENTAL DRIVERS OF CHANGES IN SIZE: WHAT HAS CAUSED GROUPS TO GET BIGGER

Myriad factors have contributed to the increase in group size in recent decades, many of which arise from extrinsic pressures felt by practice leaders. These drivers include decreases in reimbursement, the decline in independent outpatient imaging, increasing regulatory burdens, and shifts to payment models other than those based on fee for service. Pressures for compensation based on outcome measures, population health, and bundled payments all create challenges for small independent groups. Growth in size and alliance or consolidation with larger entities are perceived as solutions to these growing burdens.

This challenging environment has led to increases in corporatization and consolidation elsewhere in the health care market. In particular, mergers in the health care insurance industry, rising government share of the payer market, and growth in the size and scope of hospital networks and health systems have all created a market ethos of oligopoly and oligopsony. This includes many instances of groups' being pressured or forced to take hospital employment as part of an effort to create alignment as hospital systems grow.

These changes in the landscape have led radiology groups and their leaders to respond with growth and consolidation themselves. Strategic activity in this domain includes organic growth through hiring, mergers of existing groups, and other maneuvers to reach a size that allows local or regional dominance. For others, it means selling to a national corporation or to a consolidator in the private equity or venture capital financial sector.

ADVANTAGES AND DISADVANTAGES OF DIFFERENT-SIZED GROUPS

Both real and perceived advantages exist for larger practices. There are significant financial and technical challenges involved in running a modern radiology practice, including complying with complex data analytics–driven requirements for programs such as the Merit-Based Incentive Payment System,

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appropriate use criteria, and risk-based contracting with commercial payers. Larger radiology practices are more likely to have the resources to provide the additional infrastructure and administrative support necessary to avoid payment penalties and other financial disadvantages associated with these types of programs. Larger groups may have more leverage when negotiating reimbursement contracts with health systems and insurance providers. Some large groups may be able to self-insure, saving the profit margin that an insurance company adds to its premiums.

Larger groups may be able to capitalize on economies of scale, making practices more efficient in a profession that relies, under current reimbursement structures, on high-volume output for financial success. Around-the-clock subspecialist coverage and after-hours coverage are more easily achieved with a larger pool of radiologists, although digitization and teleradiology have minimized this as an absolute service gap for small practices.

A minimum size is required to answer the demands of some forms of subspecialty coverage. For example, many groups have been challenged by the revolution in stroke care in the past several years. Consider a group that, until just a few years ago, read everything. Acute stroke call at that time was usually limited to reading a non-contrast-enhanced head CT study, which was within the skill set of all 25 members. Fast-forward to today, and every stroke alert from the emergency department includes orders for head CT, CT angiography of the head and neck, CT perfusion, and in many cases advanced MRI. Perhaps only 4 people in the group could interpret all of those studies. With the type of call schedule in place, this could potentially fracture the group. The choices in this situation would include (1) training everyone in the group to interpret advanced neurologic studies, (2) expanding the group, and (3) seeking outside help such as a teleradiology service. These are commonly unpalatable choices for smaller groups. In many types of subspecialty coverage, economy of scale works against smaller groups.

Larger practices have an advantage in a greater capacity to diversify their workforces, which has been shown to correlate with increased profitability [3]. A small practice that hires on the basis of whether a candidate is a "good fit" or "matches the culture" of the current workforce may find itself stuck in an echo chamber without the benefit of diverse thought and experience needed for innovation and growth.

Trade-offs are ubiquitous in business, and practice size is no different. Some of the very characteristics that provide advantage for larger practices result in consequences favoring smaller groups. The larger number of radiologists affording more subspecialist coverage and increased diversity results in a lesser degree of autonomy for each physician-owner, with potentially less "skin in the game." When work lists loom large and everyone in the practice is asked to stay late to pitch in, a radiologist who owns 25% of the business may be more likely to do so proactively than one who owns 1%. Many leaders complain that as groups grow, the nonclinical work—practice building, conference attendance, and relationship building—suffers. Other practice challenges that require intellectual and emotional physician buy-in may be weathered more seamlessly in practices at which physician owners have a greater sense of ownership in the group. Financially, smaller practices may have fewer fixed costs that allow a nimbler response to economic challenges. Depending on governance structure, small practices are also typically more agile in decision making. A smaller group with a limited footprint may find it easier to develop relationships with local referring physicians and hospital administration, capitalizing on the benefits of Imaging 3.0™ concepts in demonstrating value beyond image interpretation.

Like all stereotypes, advantages of large and small practices are not universally generalizable. In fact, many of the aforementioned delineations could apply to large or small practices, dependent instead on individual radiologist characteristics and the quality of their leaders. A neuroradiologist in a 200-person group could build just as sound relationships with referring providers or hospital administration as one in a 5-person group. Likewise, a 10-person group dedicated to diversity could achieve more than a megagroup that is less intentional about inclusive hiring practices. A large group with a well-run and trusted executive committee may be nimbler in decision making than a small group with disorganized governance. The illusion that size is always better has been shattered many times in many ways in health care, including one example from one of the architects of the Patient Protection Affordable Care Act. Small groups that act quickly and decisively in times of challenge and change can provide better service than large monoliths [4].

As the coronavirus pandemic has unfolded, the notion of an optimal size for groups has been challenged. Although almost all types of practices have been challenged, both large and small groups have succeeded, and both large and small groups have floundered. Some of the larger private equity–backed groups have faced financial restructuring because of the surge [5]. Indeed, the perceived advantages and

disadvantages to practice size can be applied to groups of any size to optimize effectiveness and success.

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