SCALE + community

GI Alliance

CEO Leadership Series: Vol 26

The Future of Physician Independence Is Now

An Interview with Dr. Jim Weber, CEO/Founder of GI Alliance

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Dr. Jim Weber
CEO andFounder
of GI Alliance

Key Takeaways

Physician-led equity buybacks are emerging as a viable and compelling opportunity for the right MSO organizations.

What is the opportunity?

- Physician owners partner with a hybrid financial partner (i.e., debt + equity investor) to buy out an existing private equity partner.
- A substantial portion of the transaction is financed with debt, leaving the physicians with a greater share of pro forma equity ownership and governing control.
- The hybrid financial partner is likely to retain a minority equity ownership stake along with providing the debt financing.

When does this scenario potentially make sense?

- Strong pre-existing physician leadership, business leadership and operational infrastructure.
- Physicians own a large portion of equity prior to the buyback transaction.
- Physicians are:
  - Well-informed of the transaction structure.
  - Willing to roll their equity and genuinely want to pursue the buyback transaction.
  - Committed to the business for the long-haul and are willing to forgo short-term value realization for long-term value creation.

MSO CEOs can create significant value by actively engaging with a diverse range of market stakeholders. This goes well beyond sourcing add-on acquisitions. Creative strategic partnership development represents an often-overlooked core pillar of differentiated and sustainable value creation for MSOs.

GI Alliance's culture, strategic philosophy and value proposition is grounded in seeking new ways to help.

- **Help** improve patient care and the practice experience.
- **Help** create win-win scenarios on behalf of patients, internally across GI Alliance team members, and externally across market stakeholders.
- **Help** leverage GI Alliance's footprint to support the needs of market stakeholders.

As part of this cultural approach, GI Alliance has invited and actively pursued a diverse universe of strategic partnerships. Identifying, cultivating and executing on these strategic partnerships is a key on-going focus for the Company's C-Suite.

Partnerships have included tangible "off-market" relationships with:

- Hospitals
- Payers
- Service providers / management organizations
- Pharmaceutical companies

These relationships have often grown and yielded unpredictable ancillary value over time through mutual goodwill.

The consistency of GI Alliance's core principles has served as a stabilizing force, a credibility building fact, and a strategic differentiator in the market.

GI Alliance's most senior leadership has remained in place since its founding.

The Company's core principles have remained unchanged over time and across ownership structure as the Company has grown from 1 MD to 15 MDs to 150 MDs to 500 MDs to now 800 MDs. In priority order, those principles are to:

- Service the patient
- Serve the practice
- If successful in achieving the above, realize a profit

"When I talk to doctors that I haven't seen in a while, they say 'you're saying the same thing today that I hear you say 10 years ago.'"

The Company has, since inception, maintained an aspirational, ambitious and long-term perspective and vision as demonstrated through:

- Consistency of leadership and core principles.
- Consistency of growth and market expansion.
- Exploration and execution of unique strategic partnerships.
- Recent buyback transaction.
- Exploration of expansion beyond GI.
- Leadership continues to focus on methodical strategic plans grounded in patience, long-term vision, and strategic value propositions that transcend individual careers.

"I'm in the for the long game, not just for my career, but 50 years. 50 years down the road, I hope that GI Alliance is functionality well and that I left a legacy."

As MSOs scale and mature, we should expect to see strong market stakeholders look for creative expansion opportunities that involve moving beyond single-specialty focus.

- Recognizing that GI Alliance's core infrastructure (i.e., management & ancillary services) has strategic applicability in other specialty markets, the Company is considering a gradual migration in other specialties.
- Any expansion plans will focus on areas where GI Alliance can add the most value – "It's timing, it's synergy, it's thoughtfulness. I think anybody that jumps in too quick is going to face problem."

Disciplined add-on acquisition strategies prioritize strategic fit vs. growth for the sake of growth.

"We have been successful in partnering with or acquiring, I think, over 40 practices in the last four years. But, I think we've also turned down probably 60 or 70, because they don't all fit, culturally, geographically, business wise."

What makes for a good fit?

- Tier 1 Priorities
  - Bi-directional cultural fit.
  - Ability to work together.
  - Add-on practice has a genuine desire to take their practice to the next level.
- Other Key Criteria
  - Bi-directional value-add / synergy.
  - Geographic fit / favorable market.
- Lower Tier Criteria
  - Practice size is not a major factor. Solo practices tend to be more challenging to acquire but size is otherwise not a driving criteria – "we've brought in groups of three, and 30 and 90."

Building a scalable culture & program across a national footprint

Core principles for approaching physician management & engagement

- **Transparency:** "I would say the most important thing is making sure that we have been transparent with the doctors, that they understand what they're getting into, they understand what's happening as it's going on."
- **Patience:** Change is gradual and is often implemented by showing not telling. "It takes time and energy, but we give them a template...I think some of that patience and flexibility has really allowed us to do more with more quality groups than if we came in hard and said 'This is the way we're going to do it and you have to do it this way or you can't be part of this organization.'

- **Alignment:** "We have one MSO nationally....everybody's in this together...we felt one model, one MSO made us truly one organization."

Core principles for approaching physician compensation:

- **Choice:** Offer choice vs. one-size fits all compensation model to allow providers to choose their destiny
- **Structure:** Create parameters so that the model does not become too cumbersome – e.g., offer three defined models to choose from and allow no more than one model per practice.
- **Patience / Transparency:** "We let them stay on their productivity models to start with. And then, once they were in the group for a series of months and we could show them the data, we compared it to their legacy model, and then they were asked to pick one of those three models."

Core principles for scalable organizational structure:

- "We divided the country into regions. Each division has a trio of a clinical lead, a financial lead, and an operational lead. And those all have reporting mechanisms up to our national structure of a national COO, national CFO, national CIO, etc."
- "Our physician executive board is made up of individuals who are the chairs of each of the divisions. And they have regular meetings that we attend from a national level, but we also allow them to have a more local meeting....Every practice has a seat on their divisional governance board, they choose their chair, that chair sits on our physician executive board."

Background

Chief Executive Officer and Founder of GI Alliance, Dr. Weber leads the nation's largest independent gastroenterology (GI) provider network. His vision of creating a premier GI network by being Patient-First, Quality-Centric, and Physician-Led drives the organization's success. Dr. Weber reinforces his Patient-First vision through current GI practice, providing care to patients at GI Alliance's Lone Star Endoscopy in Southlake, Texas. In 1995, Dr. Weber founded Texas Digestive Disease Consultants (TDDC) and served as president until starting GI Alliance in 2018. GI Alliance consists of Gastroenterology groups across Arizona, Arkansas, Colorado, Connecticut, Florida, Illinois, Indiana, Kansas, Louisiana, Mississippi, Missouri, Oklahoma, Texas, Utah, and Washington state.

Jim Weber

In the early 1990s, as broader changes were being contemplated across the national healthcare landscape, one of our major payers decided they would only accept providers that were willing to take on capitation. I responded to the RFP by cold calling every doctor in North Texas and formed an IPA and won the contract. I came to realize the value of data, the value of working together with other doctors, and the value of being able to provide good care and controlling how it was delivered. But, I also realized that not all doctors and all practices were the same. I put together a group at that time, in 1995, of some of the best practices in North Texas and became a large group that included 15 doctors.

I started then really trying to see how we could work together. We formed a central business office, put together a pathology lab, started anesthesia with CRNAs, built a couple of surgery centers. From there, people started asking to join and be a part of this - seeing the value of working together, the value of negotiating together, the value of centralizing some of these processes. This project became very successful and grew to about 60 doctors in the Dallas/Fort Worth area.

Then, I realized I could maybe spread out across the state. We took a long time, but we got to be about 150 doctors throughout the state of Texas and were able to then negotiate statewide contracts and things like that, that were really very, very valuable to the organization. At that point though, it was really my administrator and me running things. I realized that we needed help and looked at multiple ways of getting it. Ultimately, I turned to private equity. But we did in a way that was very selective in saying that we wanted physicians to lead the organization. We wanted the physicians to have ownership. I was fortunate in 2018 to partner with Waud Capital.

Waud Capital allowed me to be the CEO and allowed us to run the organization. Waud did put fuel on the fire and helped us with some business knowledge and with building an infrastructure that allowed us to grow to about 500 doctors in a couple of years. But, then the doctors and I really wanted to take back more ownership. We looked for a partner who would provide us with capital and access to some of the same resources we had at a higher level, while also putting us back more strongly in control.

And, when I say control, I mean control of the board, control of the business decisions, and increased ownership control of the MSO. We ended up partnering with Apollo Value Hybrid who was set up just to do that. They provided the capital to buy out Waud Capital and pay off our debt. The doctors rolled all of their equity forward, increasing our stake from 50% to 85%. With that, I became Chairman of the Board. The physicians controlled the Board, they controlled equity and the business decisions, and yet we had access to the resources of Apollo with $500 billion in assets and all of the other resources they have.

And, it's been just phenomenal. We have really enjoyed being back at the helm and running this. We're now over 800 doctors in 16 states. We have an incredible executive team and an incredible physician executive team. And they work very, very well together. I think one of the keys to our success is the physician executive team. Everything has to go through them, but they work hand in hand with the executives and understand the value of that relationship to make the business better for everyone. And anyway, that was very long-winded, but that's where we are at now.

One of the things I get most excited about in healthcare services is observing different ways of building healthcare service platforms primarily from a concept of ownership. Ownership has such a huge impact on what a business does, a mostly understated impact when you really connect the dots. So the fact that GI Alliance is back in physician hands is just so exciting to me.

How do we present to our SCALE Community physician audience across the country a vision that they can relate to? The skeptics and the nervous physicians that haven't done anything like this before would look at what you've done and say, "Well, that's Jim Weber. I can't do that. That's GI Alliance"?

It's a great question. I do think Apollo Hybrid Value is not the only financial model that one could turn to. There are others out there that are doing this. I think it is a very viable model and this doesn't have to just be GI Alliance - it can be many other organizations.

I think it does get very hard once somebody has gone too far down the path of selling out too much of their equity because you have to have enough starting equity to be able to execute on a model like this one. And, the doctors in your organization have to really want to do it. But I think if the doctors want to have more equity, want to have more control and aren't looking for a quick retirement plan in cashing out, then this is actually a very, very viable model for anybody looking at it, whether they've started with private equity or a financial partner or whether they haven't gone down that path yet.

This model would actually make sense for those who have a growing corporation, business, practice and even if they already partnered with private equity but still maintain a significant amount of equity and have a group of physicians or business people that really feel that maintaining equity is critically important like we did in our organization.

I think the standard private equity companies will be a little bit nervous about this type of model, because they want you to feel like you have to have them, you need them. But, I think everybody knows that a private equity company operating under the traditional model is a very temporary partner. They come in, infuse some capital and some business know-how - and that's fantastic - but they're there just to get that final return. The way our current model was set up is that we've allowed the financial partner to have a little bit of equity so they have some skin in the game. And, they get a little bit of interest on some of the money they put in. But, we really have taken on less debt, we are levered less, and we have access to more capital. The doctors are, let's say, deferring that gratification of some payout at that turn that we did. In turn, they're building their own value and equity in their business. And they will get rewarded very handsomely when they retire and get to then have this retirement nest egg that they're building. They're investing and building in themselves and in the organization. I would venture to say that this model could work for many, many people, and could be very viable in many of my colleagues' practices.

It makes sense if you look at other industries. The concept of a management led buyout, which is often a founder led buyout, is tried and tested over decades. This concept of, I'll buy my company back, is well-documented and has many successful case studies across many industries. So, it really was just a matter of time before physicians realized that they could fall into a similar category where it's a question of finding an institutional partner, and then coming with that partner to your current institutional owner at the right price and doing a deal. It's just incredible to see that GI Alliance has led, again, not just in the GI specialty but also in the concept of finance and in M&A and deal structure.

Well, one thing I would say is that I have been very fortunate that under the prior term of ownership, we built strong infrastructure and brought in really bright business people - a really good CFO and operator and legal counsel, etc. I would not have been bright enough on my own. I might have wanted to do this early on, but I did need those people to help because as much as it makes sense and is not that complicated, you certainly want to make sure that you have some good financial business people supporting you in these models. It actually put us in a better place financially. We also did retain a banker to help model the buyback transaction with us, with my team, so that we were in a good place to understand exactly what we were doing. Just a caveat, just to make sure that I'm not smart enough to do this all on my own - it took a team.

I want to pivot to GI Alliance as a business today and ask some core questions around the business itself. The first question I have is, as a leader in the space, how do you think about strategic partnerships? Where do you look for your strategic partnerships? And you can include health systems, payers, other MSOs, non-healthcare entities that might be wonderful sources of referrals for you, marketing partners. How do you, as the CEO, sit at your desk in the morning and think about what GI Alliance could be doing in terms of these partnerships?

Another great question. I've spent a lot of time thinking about that and I think one of my successes in my position in having the privilege of leading the GI Alliance is the relationships I've built and partnerships I've had with different organizations. I start with the hospitals, who many of us view as our enemy and competitor – and, rightly so in many ways. But, I say I am not just agnostic to the hospitals. I'm actually polytheistic.

I realize that we have to work with the hospital systems - my doctors work there, we have an active working relationship, we are both caring for the patients in our community. So, we try as best we can not to be at odds with them. How can I do that? Well, I do that in many ways. For example, we provide services for the hospital, such as caring for the indigent, unassigned patients that come through the ER. Many times, we partner with hospitals in our surgery centers that are in their neighborhood, and we ensure the systems have skin in the game, in the surgery center. That makes the hospitals want the referring doctors to use our facilities. When we are providing care in the hospital, I don't do it for free - they have to pay me a stipend - but it's much cheaper for the hospital versus them going out and hiring other full-time doctors. These types of initiatives keep us on the same team.

In the same way, with ASCs, I've found many ways to not just partner with hospitals, but also have good partnerships with a third parties such as USPI, SCA, HCA and other similar organizations.

We've developed a relationship where we've created a financial model that is a win-win for everyone.

They win because they get to help us, get to have some equity and be involved. We win because I can often get better rates for my doctors. The doctors win because they get better reimbursement and have multiple teams working with them. It's also led to us to opportunities in other markets where they say, "We have this opportunity here, would you be interested?" Or, "let's build a center here together." That's been phenomenal.

We've also partnered with the pharmaceutical companies in ways where we've had access to medications that we might not otherwise have had access to, as well as have received better pricing on medicines for being their lead or for doing research on medications in a clinical setting.

That's through your GPO partner or that's separate?

No. That's through all sorts of relationships. We do have a relationship with a GPO partner that's been very good, but we also have direct relationships where we work with pharmaceutical companies and talk directly with them. One of the things I do is I'll give a talk to their key leaders about who we are and what we are and why we are doing what we're doing. And, as they get excited about it, they almost become salesman for me as they go into other offices and tell them, "Well, look at the great things that GI Alliance is doing."

And I'd get phone calls from doctors saying, "Hey, we heard about you through a pharmaceutical representative or something and we'd like to know more about the organization and maybe how we could join you or work with you."

And, then there are the payers. I meet with the payers regularly. Again, many people find the payers very hard to work with, and they are, but you have to work with them. I mean, they are who pay many of my bills. I offer to work with them on how we can better care for patients. Can we do a value-based care arrangement? Can I discuss with you how a particular issue with the pharmacy service or something else is affecting patient care? Having that type of communications relationship has been really critical.

Those are examples of some of the major partnerships relationships we deal with. And then, obviously maintaining every kind of vendor and partnership relationship becomes critical to having a successful organization, having a good name out there in the community. Then, these partners tend to want to try to help us and see what we can do together. I've had some of my industry sponsors help us with recruiting and other things that have been thinking outside the box or some legislative assistance and things like that. I think such a huge and critical piece of our success has been those relationships with all those different individuals and organizations.

You're the person to ask this next question. GI Alliance clearly has had a vision of where it's been going over time, measured in increments of five year periods, 10 year periods. One of the beautiful things about GI Alliance is, almost like a good sports franchise, it's had the same CEO for a long time. And so, there's continuity where you can actually have confidence in that vision that you'll actually get there. So, today, there are 25 brands across GI Alliance. What does the business look and feel like 10 years from now? What are the similarities as compared to today? What are the key differences relative to today?

Well, I love what you said about the continuity and one of the things I think that has made us successful is when I talk to doctors that I haven't seen in a while, they say "you're saying the same thing today that I heard you say 10 years ago." That it's all about the patient and that the GI Alliance is there first and foremost to make sure the patient is well cared for. And then, second to support the practice and its people. And third, if we do that right, to make a profit. And that you haven't changed in worrying about making a profit being the leader of these goals.

I call that the three Ps in that priority order - patient, practice and profit. And, I think that needs to be clear. I also think that one of the things we've done has been to always make sure we do well in what we know we need to do well to help support practices, the ASCs, the ancillaries, and again, supporting the practice and ultimately making sure the patients are well taken care of. So I hope that 10 years, 50 years from now, that will be our mantra still.

That being said, what we have been very focused on is gastrointestinal care. I think that remains our focus for the near future. But, as we have built this infrastructure that I've talked about of really phenomenal executives that support our physician executives on managing practices, surgery centers, pathology, anesthesia, pharmacy, research, infusion, chronic care management data, data management, etc. we realize there are a couple other specialties that are doing the exact same thing.

And I think one that stands out is urology. If I go down that list, they do exactly the same thing. And urology is a little newer maybe to having financial sponsorship and are looking to how they do these similar things. So, it's not a secret, I guess, that we are having some discussions with some of urology practices and considering whether it would make sense to maybe do collaborate with a similar specialty and partner with them in a similar fashion, having built that infrastructure to do all the same things that they're looking towards. And I'm not a urologist, but I am a physician and I look toward physician leaders in each of our areas to lead. But that's one area – expansion into urology – that we're looking at.

Also, expanding our different ancillary service lines and being better at managing and running ASCs and pharmacy and infusion. We've done a really good job, but can we expand even further?

So I think that 10 years and beyond we are still about supporting practices and caring for patients, but could that expand beyond maybe just pure GI? We've already gone into pediatric GI, colorectal surgery, and we have some anesthesiologists and radiologists, but I think that's supporting cast. I'm not going to be all things to all people.

But I think that if you know what you're good at and stick to your mission and vision of patient care and supporting practices, that we could expand our template a little bit further in the next five to 10 years.

I think the timelines and the sequencing are very important. The difference between moving into five different clinical specialties over a 10-year period and moving into five different clinical specialties over a 50-year period, very different. But, very few leaders of MSOs think in terms of multi-decade timelines.

And when you think about the many brands that you currently manage, does GI Alliance one day act as a parent co-brand, but really what's driving the outreach is these sub-brands that are not necessarily specialty dependent, right? That gives you flexibility to move into new specialties too, but again, very carefully. It's all about the sequencing and finding synergy every step of the way.

You're spot on. It's timing, it's synergy, it's thoughtfulness. I think anybody that jumps in too quick is going to face a problem. And even people reach out to me and ask, "How are we able to do the GI Alliance because I want to do that now?" And I'm like, "Well, I've been doing this for about 20 years. So it's not like I just thought of it and it's started."

I opened the conversation with mentioning that I started by myself and slowly built it up for different reasons and thoughtfully brought in the right groups. And, so the other thing I would say is that one of the keys has been bringing in the right partners and groups. We have been successful in partnering with or acquiring, I think, over 40 practices in the last four years. But, I think we've also turned down probably 60 or 70, because they don't all fit, culturally, geographically, business wise.

Sometimes saying no is as important as saying yes and being thoughtful and careful about it. And I'm in for the long game, not just for my career, but 50 years. 50 years down the road, I hope that GI Alliance is functioning well and that I left a legacy. I'm not doing this for the short term, for sure. So thank you, for those comments and questions.

GI Alliance has acquired a lot and acquired well, very well. But I also want to qualify what acquiring a lot means. Big difference between one very well-suited large acquisition and 10 acquisitions, five of which are not good fits. And so, talk to us about your methodology.

What I would say is that I open every discussion with what I've talked about just a moment ago, background on GI Alliance is trying to do. We're trying to care for patients, support our practice. We're in this for the long haul, we're trying to create something sustainable, maybe transformational, but something really good. And we want practices that can add that same thought process and passion for patient care too.

For every group that's come in, I've had the chance to visit with them upfront and make sure that these are physicians that are truly passionate about their patients, passionate about quality care, that they have something to offer. And they will often tell me, you don't sound like private equity. I said, "I'm not private equity, I'm a physician and I'm wanting to partner with other colleagues that have the same mindset."

And I'm very proud of the groups that we brought - that they do believe. That is why they work so well together and with us to try to continue to grow this and make this organization a good one. And it's only later in discussions with potential partners that we get into any kind of financial structural discussion, which is also important. But if, upfront, I don't feel that the culture's there, if they don't feel it's there and we don't have that same kind of vision and direction, we just don't go down that path.

I think that that's why we often say we've been able to work with other like-minded practices because of that. And I think it's key. And it is pretty easy actually once you get into a discussion of whether people are in this for financial motivation only, short-term gain or retirement plan or if they're really in it to help support their practice and their patients and build something to work with us so.

I agree with you that culture is 90% of the evaluation and often gets overlooked because it's so ambiguous, and so intangible. And so, that really is the rub, right? The thing that is the most intangible is the most important.

Absolutely. I mean if people ask me what are the three most important things I say culture, culture and culture. But it certainly goes beyond that. I mean that is the key. I can't create culture in a bad cultural organization.

I can enhance culture with somebody who's already got that ability to work together and that passion for the patient when I kind of grow this.

And I will tell practices as we talk to them, if GI Alliance can't add value, you shouldn't join us. But I've also realized if they can't add value to us that we shouldn't have them be part of the organization.

And what does adding value to us mean? It means that they have that kind of ability to work together. That they have a desire to take their practice to the next level of care. That they're in an area that we can grow and in which we can be sustainable. I have found that there are certain markets that are very hard because of government regulations, state regulations to go into. I have some trepidation about California, honestly. We will eventually go there, but right now it's just a struggle for us. And I have some good friends in the state who've asked to join and I don't have the bandwidth right now to go into California.

We had a colleague hear us talk and he was from Japan and was expanding out into different countries in Asia. I spent some time talking to him and giving him some ideas and help. And my partners were like, "You won't go into California but you'll go to Vietnam and Indonesia?" I said, "Well, I think they're easier." Anyway, so I agree with you. And I apologize to anyone in California and God bless you and we will be there someday, but it's a heavier lift, for sure.

What about size?

Size isn't that important to me, actually. In the past 25 years, the hardest groups I've brought in are individual doctors and I realize they're an individual practitioner for a reason. And that's where I go, can they work together? But if there are three doctors, that's fine. It doesn't have to be 30 or 90 – we've brought in groups of three, and 30 and 90.

I think, first of all, do the doctors have the cultural fit? Second, are they willing to, as a team, to work with our team? Are they in a geography that's good? Are they in a market that we can help support with better contracting and things like that, and that we can recruit to? That has become an important thing. Physicians all want, "Oh, can we help them recruit?" And we have a very robust physician recruiting program, but it is hard to recruit to some little towns - that's very difficult. So, where we can help? It's kind of a back and forth where we can add value and where they can add value and all those factors play a role.

So building all the departments that you've built, which of them has proven to require the most effort and focus? Is it perfecting integration and your integration capabilities? Is it, as you mentioned, the recruiting department? Is it marketing, data analytics, payer contracting, RCM? And you have inbound systems and ways of doing business, these different practices, they in-source some items, they outsource historically some items. Is it compensation and managing the different compensation structures?

I always say there are two things that doctors really get worked up about and it's compensation and schedules. So, we certainly have to address both of those issues. I think every single thing you listed, we have put a lot of time and energy and effort into. All of them are very, very important. But I would say that the most important thing is making sure that we have been transparent with the doctors, that they understand what they're getting into, they understand what's happening as it's going on.

And a lot of that's tied to their compensation honestly. Most of the doctors that joined feel like things didn't change much since they joined, but now they kind of see what's happening and we try to give them a path. And it takes time and energy, but we give them a template where they not only see how they are performing financially, but how it would affect them if they maybe saw one extra patient or did one extra procedure.

And I don't think that's information that the average doctor had or has and it is very valuable. They realize I never tell somebody to work harder. I actually tell them I would like them to work the same and just be rewarded better for that work. But if I can show them, if we can be more efficient through the surgery center or the office and their day is easier, but they saw one or two more patients, how impactful that is to the bottom line?

So I think making sure that the physicians are engaged and that they understand and that they are compensated fairly is really critical, because you can do all those other things well and if you don't have them aligned and understanding what's going on and being compensated properly, you'll have a problem.

You can have the best marketing department in the world, it's not that valuable if your physicians aren't happy. And so, the amount of time and effort spent on getting it right - there is no limit to that. And so, it's just amazing to hear you really reiterate that.

So when you think about the structure of your MSO, how many different compensation formulas are out there across the country? And also the concept of national MSO, one singular MSO versus a national MSO and multiple separate regional MSOs? You must have committed to one of those models versus the other.

You asked a comprehensive question with two major points. How do you structurally function as an MSO? And then, two, how do you do it down to the compensation model?

So on the MSO level, we've spent a lot of time developing this and if you look at our legal structure, it looks like a geometric jungle gym. But it's really quite simple in that we did it in a way that we have one MSO nationally. We think of ourselves as one practice. It's one management service organization, but I say it's like one practice because we can share ancillaries across the entire nation if we want to. We can have the same stock, we can have the same everything.

Everybody's in this together. It's not like Dallas is competing with Chicago or Chicago's competing with Hartford or Seattle. This makes it so that everybody is working in the same way. We share the cost of the MSO, we share the benefit of the MSO, the benefit of the growth of it. So we have one national MSO. I've seen many people do it regionally or even smaller locally, but we felt one model, one MSO made us truly one organization.

Now, that being said, on the compensation side, I know many private equity backed organizations have a very rigid construct that if you join, this is how we do it. Everybody gets paid the same way. And that didn't work for me. It didn't work for our practices and it would've really hindered our growth. We were very flexible on this topic - and yet you can't be too flexible at the end of the day as you grow a large organization or it becomes so complex and difficult. And, I talked just previously about transparency and showing doctors finances and how it affects our compensation and that would be very difficult if we didn't have it standardized.

What we did, what I did 20 years ago, was I let every group that came in have their own compensation model. That was too much. What we did is we said basically it breaks down into three compensation models, either you shared everything, you got paid for your performance or you had a blended model.

So, we created three models. And those three models of productivity: 100% productivity; or equally shared within a practice; or a blend of it.

We were able to, with three simple models, fit everybody within less than 5% variance of what they had done previously and we showed them that. And what we did is let them stay on their productivity model to start with. And then, once they were in the group for a series of months and we could show them the data, we compared it to their legacy model, and then they were asked to pick one of those three models. And that has worked really well for us. It gives them some flexibility and choice, but it makes it more standardized because we're down to three for the organization at large. So that's how we do it.

Again, patience in adopting changes sequentially over time. First step, education, you let months go by of a new physician just getting comfortable, at peace with the change. Then, you offer the change, they pick one voluntarily, then it begins. It's just very different than here's the business that you're now part of, this is your new compensation formula, good luck.

And we do that same variability with even how we acquire a practice. We truly do buy the practice, but we give the majority of all the profit back to the doctors. If they have ancillaries, we acquire them, and then we optimize them or incorporate them into what we have. But let's take surgery centers for example. Many platforms say we have to have ownership or we have to own 51% or 100%, but we're absolutely flexible.

Look, you have a great ASC. That's important to you. You can own that. We don't have to own any, but we want to be involved with it and we're going to help you with the pathology and the anesthesia and we're going to get all sorts of benefits and they're going to get all sorts of benefits. And that flexibility of allowing somebody to sell us 30%, 50%, whatever, has really made them very comfortable in like, "Wow. These guys aren't trying to take over everything."

And many times, they'll want us to acquire more of it to help them with those things. So I think some of that patience and flexibility has really allowed us to do more with more quality groups than if we were just really came in hard and said, "This is the way we're going to do it and you have to do it this way, or we're not going to, you can't be part of the organization.

Do you expect a drop-off in performance year one post-acquisition? Because that's just so normal that dust has to settle, everyone's learning about the things they didn't quite know about sometimes very innocently when a change of ownership takes place or have you found that the structure that you've built is so strong that you really do hit the ground running with all these new assets day one?

I anticipated when I had a financial partner that when a group joined and they got a paycheck, that productivity would fall off, at least initially. I've been pleasantly surprised it was just the opposite. People have worked at the same level and many and often the highest producers have actually produced even more. And I think across the board, we see within a very short time that there's really an uptick in productivity of about, I think it's about 10% across the board.

I think part of it is because I've been told this by many doctors that they're kind of re-energized. They feel good about it. They were getting a little burned out and run down and worn down. I'm getting beat up by the hospital, the insurance company, the government, whatever.

And all of a sudden they feel like, "Wow. I can really just practice medicine again. They got my back covered and everything's going to be okay and I can just get back to really working."

So we've actually seen, amazingly, the productivity's actually gone up without asking them to do it just because I think they're re-invigorated coming in and being part of this.

What is your practice philosophy and your personal philosophy on physician reviews? What is that balancing act between measuring true clinical quality through an HCAP survey versus online reviews that arguably diminish the credibility of a doctor? What is your take on that and what tools do you present for the patient to make those decisions without undermining the doctor?

I think it's such a great question and physician reputation I think is a big deal, especially as our world has changed. And I would say in GI, a majority of our patients are, the mass majority are self-directed. They don't come through a referral from an internist or their family doctor, but rather they go online and see who's the best doctor. And unfortunately, a lot of these reviews that are online are not good.

I talked to a small group yesterday and I said, "You guys seem like really good guys and everything I've looked about you, you're quality. But, boy, your reviews online are terrible." But then, you look at it and they have four reviews. They got a good one from their mother and then they got a bad one because they couldn't get in that hour that they wanted to get in or somebody didn't smile at them at the front desk and it had nothing to do with the doctor at care, but that some annoyance that came in, and so they did that.

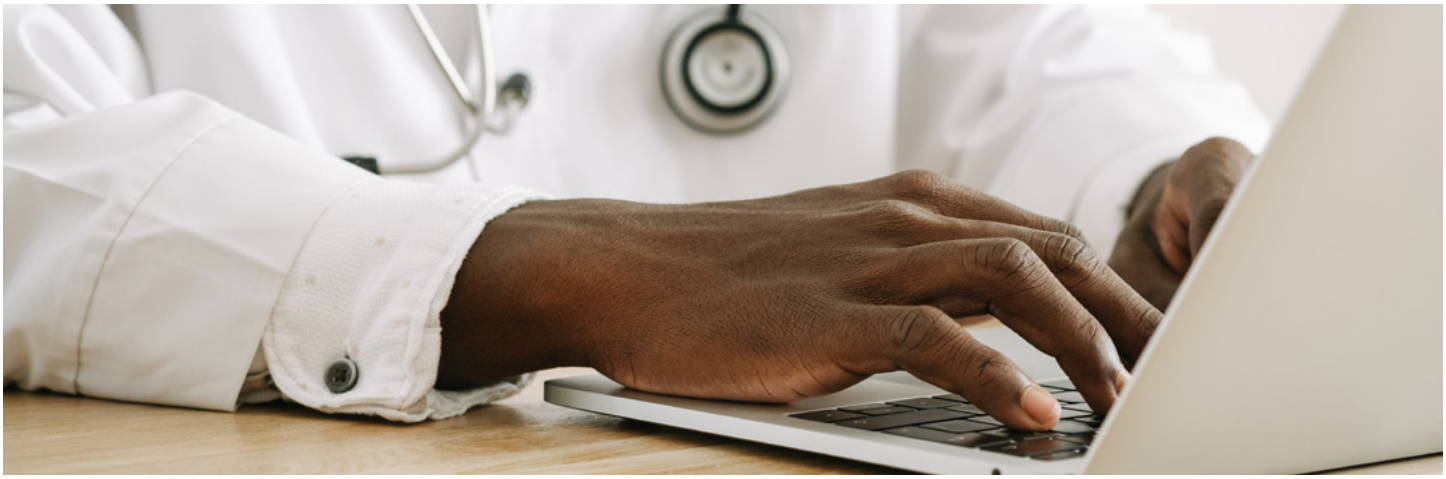
It really is on my marketing team and they can tell you the details of it, but it was really important to me that we spent time making sure that we got those positive reputational review out there, not falsely, not like a car dealership like, "Hey, give us five stars or we won't sell you a car." But rather the mass majority of patients for a good doctor really appreciated the care they got and enjoyed their visit as best you can and have good things to say. But they don't take the time to comment.

We give every single person that comes in, if you had a pleasant visit, a good visit, please fill this out for us and put it online. And we've gone from four reviews to 4,000 reviews for each of our doctors. And, amazingly, in a five star review, they're all four plus because they're good doctors and they were liked by their patients. The patient just didn't really have a mechanism to answer that.

And what we then ask is, if there was a problem, why don't you talk to us about it? Let us work through it. They then realize they're getting that personal attention and we're taking care of them, but then they don't post a bad thing on us. So I think we get the good and the bad that way. I think it's really important.

I would say the other thing we've done differently is around branding. Instead of telling people that we've had this GI Alliance name and reputation forever and we're going to brand you GI Alliances across your head and take away your name and leave people confused, we actually allow everybody, if they want to, to keep their name and just say Powered by the GI Alliances under their name. So that they're part of the GI Alliances family, but we haven't taken away the good name that they built over many years.

That being said, many of our practices say, "Can we just become the GI Alliance of Chicago?" And I said, "Sure. You can do that." And again, it's been a gentle push rather than a forced marketing or branding opportunity and I think that goes along with everything that we've talked about today.



You're quite a sizeable organizational with a broad geographic footprint, and yet there seems to be strong transparency, engagement, and a real culture around what it means to be part of GI Alliance. I'd be curious from a people, organizational chart and governance perspective how you maintain that connective tissue across the footprint.

JWhat a great question and I should have gone there. Thank you. I think that it's critical. I think one of the things that's really important for physicians is to feel they have a voice and it's not just the physicians, it's their administrative team that they feel really good about. What we've done, it doesn't matter how big we get, we've divided the country into divisions. Each division has a trio of a clinical lead, a financial lead and an operational lead.

And those all have reporting mechanisms up to kind of our national structure of a national COO, national CFO, national CIO, et cetera, who all report me. That allows regular interaction with all those people - regular meetings. My physician executive board is made up of individuals who are the chairs of each of those divisions. And they have regular meetings that we attend from a national level, but we also allow them to have a more local meeting.

So I think what I'm saying, well, I know what I'm saying is that it is critical that each of the areas are represented. Every practice has a seat on their divisional governance board, they choose their chair, that chair sits on our physician executive board.

That physician executive board then gets to interact with at every level. And we do that on the financial side, on the operations side, on the HR side, IT, et cetera. So there are local boots on the ground, regional support and the national oversight. That's how we structure it.

And so, it's just wonderful to see that on every question that I ask, you are offering leadership, not just physician buyouts, but everything. And so, it's just a wonderful example for SCALE Community our audience, which grows and grows, to just slow down and take note of how to do things right. The best competitive advantage I've ever heard anyone describe is 20 years, the concept of time. You can't go out and buy time, it's not for sale. And so, it's just amazing to see the power of that manifested in what you've been building. So just my hat off to you, all of our hats off to you and just really appreciate your time this morning.

Well, thank you and thank you for the opportunity to talk to this very esteemed group and hope it was a little bit of help. So it was my pleasure. Thank you very much for the opportunity.