New payment models: Decide a practice setting

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Hypothetical

You are a member of a six-person family medicine practice in a city with a population of one million people in the Midwest. Your practice is very busy, with most commercial patients coming from three major insurance payers in the city. About 60 percent of your practice is commercial and the remainder is largely Medicare. You have very little negotiating leverage with the insurance companies, and as a consequence, your reimbursement has been consistently declining in the last years. Recently, you did receive an increase in commercial payment rates, but it has not resulted in a significant improvement in your practice revenue. However, you are concerned that the changes in Medicare reimbursement required by the MACRA legislation will result in reductions in Medicare reimbursement and increased regulatory costs. Nevertheless, on the whole, it is a comfortable practice with adequate income at present, but you are concerned about the future.

Your city is dominated by two hospital systems: one is a for-profit and one is a nonprofit. Recently, one of your member physicians was approached by the nonprofit hospital, seeking to employ the practice as part of the hospital's effort to form a state-wide accountable care organization (ACO) with other nonprofits in the state to serve Medicare patients. The members of your group are very conflicted as to the correct direction, and a number of physicians feel that they have little choice but to accept the hospital's proposal. You have been assigned to seek advice on what would be the best choice.

The hypothetical above is just one example of the hard choices physicians have to face in today's very complicated health care world. This physician guidance from the American Medical Association (AMA) will, hopefully, give physicians facing these choices some insight regarding the complex factors influencing their practice and the options that may be available to them for negotiating a viable path through the environment.

Physician environment

Why are physicians having to make these difficult choices? What in the environment is creating all of these enormous pressures requiring physicians to do something other than simply practice medicine? Unfortunately, the answer is very clear but daunting: the uncontrolled rising cost of health care. Although there are other issues that have some impact on the changes that are occurring, this unrelieved increase in the cost of health care is by far the largest factor forcing change. Just a few facts illustrate the significance of this intractable problem.

- In 2014, health care expenditures in the U.S. exceeded $3 trillion with costs per resident at $9,523 per year.[1]
- In 2014, the percentage of gross domestic product (GDP) spent on health care was 17.1 percent. The western country closest to the United States in health care expenditures is Sweden, where 11.9 percent of its GDP is spent on health care.[2]
- Despite all the spending in health care, quality—as tested by infant mortality and life expectancy—in

1 Health Spending Explorer, Kaiser Family Foundation, at http://www.healthsystemtracker.org/interactive/health-spending-explorer/?display=Per%2520Capita%2520%2524&service=

2 The World Bank, Health Expenditure, (%of GDP), accessible at http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

the United States fares worse than most developed nations.[3]

- In 2016, average annual health insurance premiums were $18,142; in 1999 family premiums averaged $5791.[4]

These rising costs are insupportable by the state or federal governments, the employers who pay the premiums, or the patients who pay the co-insurance, particularly when the United States fares so poorly on international public health scorecards. Although the implications of this increasing pressure on the economy are complex and far-reaching, it is safe to say that all of the following environmental factors causing physicians to consider changes are driven largely by this consistent cost pressure on the economy.

1. Declining reimbursement

Physician reimbursement has been declining in the United States for a number of years. There are a number of factors driving this decline:[5]

(a) Pressure to slow cost increases. Insurers, employers, and public payors are constantly trying to slow health care inflation. An easy target is physician reimbursement. Consequently, many payers consider managing, or reducing physician fees as an important factor in holding costs down.

(b) Lack of negotiation leverage. The Federal Trade Commission's and the U.S. Department of Justice's present interpretation of the antitrust laws hinders independent practices' ability to jointly negotiate with health insurers. Since most physicians practice in independent, smaller groups, they cannot unite to negotiate for higher fees, unless the physicians (1) share substantial financial risk for health care services (e.g., via capitation) or (2) are clinically integrated. Unfortunately, delivery models involving physicians' assumption of such financial risk have fallen out of favor with many purchasers of physician services. At the same time, as currently interpreted by the U.S. Department of Justice and the Federal Trade Commission, the standard of clinical integration sufficient to justify joint price negotiations is too demanding. Consequently, most physicians have very little ability to negotiate higher rates with health insurers. Instead, the health insurers have been able to reduce the rates paid in order to keep their health care costs lower. In some markets, large groups can negotiate higher rates, but this is not the common experience for most physicians.

(c) The increasing cost of medical groups. The costs of operating a medical group have continually increased. Everything from rent to labor to malpractice costs have continued to go up and technology costs for physician-owned multispecialty practices have increased by more than 40 percent since 2009.[6] Thus, physicians are caught between decreasing reimbursement and increasing costs.

(d) Restrictions on revenue diversification. In order to make up for these decreased fees and the rising cost of practice, physicians have increasingly relied on ancillary service income to supplement their traditional fee-for-service income. However, due to the focus of the federal government (and increasingly, state governments) on concerns regarding kickbacks to physicians, the government regulatory apparatus has concentrated on restricting this ancillary income as much as possible. It is very easy to recite numerous examples of this policy, but a few will suffice.

- Doctors have in some cases tried to supplement their declining practice revenue by jointly owning imaging centers. Several groups can support an imaging facility whereas one small practice does not have the necessary volume of patients. Regulators have seen these types of imaging joint ventures as an attempt to generate money from referrals and consequently have attempted to limit the availability of physicians to form these shared centers. Federal regulators have restricted the ability to share imaging centers by limiting "per click" leases and preventing doctors from charging Medicare more than it costs the physicians to deliver such imaging services through the anti-markup prohibition. These changes were specifically designed to restrict or even eliminate shared imaging centers.
- Doctors have sought to supplement their income with ownership in ambulatory surgery centers (ASC) and hospitals. Medicare has substantially reduced

3 Organisation for European Economic Co-operation, accessible at https://data.oecd.org/healthstat/infant-mortality-rates.htm

4 Kaiser Family Foundation, Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999-2016, accessible at http://kff.org/interactive/premiums-and-worker-contributions/#/?coverageGroup=family

5 Physicians Practice, 2011 Physician Compensation Survey, *Are the Sales Shifting?* (Nov. 19, 2011); Physicians Practice, 2016 Physician Compensation Survey (Dec. 1, 2016).

6 http://www.mgma.com/about/mgma-press-room/press-releases/2016/healthcare-technology-costs-top-32-500-dollars-per-physician. Physicians Practice, *Keeping Medical Practice Overhead Down*, (Nov. 7, 2016).

ASC reimbursement for non-hospital owned ASCs.[7] And in 2010, the Patient Protection and Affordable Care Act (ACA) outlawed the ownership of hospitals by physicians if those hospitals were not owned by physicians on March 23, 2010.

An objective look at the regulatory direction of both state and federal governments demonstrates a consistent pattern to reduce or eliminate the ability of physicians to obtain any revenue from services other than those that they perform as physicians.

(e) Increasing competition. The growth of hospital-owned practices has created competition for traditional physician practices. Larger delivery systems have substantial access to capital and resources, which allows those systems to build new facilities with new equipment in close proximity to existing physician practices. Essentially, these hospital-owned groups are competing aggressively for commercial patients.

2. Change in culture

In addition to the oppressive financial pressures faced by physicians, there are lifestyle pressures as well. The growing regulatory demands of governmental and insurance programs require that physicians spend ever-increasing amounts of time dealing with administrative issues. The list goes on forever, but privacy and confidentiality, patient consent, billing, occupational safety, retirement plan, employment discrimination, fraud and abuse, and electronic health records issues are just some of the areas of regulation requiring administrative oversight. These are not insignificant, trivial concerns. If a physician has a problem with fraud and abuse or Health Insurance Portability and Accountability Act (HIPAA) compliance, the fines can be substantial, and some of the violations are subject to criminal charges. The same can be said of Occupational Safety and Health Administration and environmental issues. Consequently, in addition to practicing medicine, physicians must operate a very complex business overrun with regulatory requirements. The present-day physician must spend a substantial part of his or her time overseeing these administrative requirements or spend a substantial amount of his or her income in paying others to do this oversight. The practice of Marcus Welby is a mythological vestige of the past.

Meanwhile, many of the younger physicians now coming out of medical schools are much less interested in long hours and greater responsibilities. Instead, many younger physicians value increased time off, reduced administrative responsibilities and less leadership responsibility. This change in the goals of physicians creates new economic pressures on medical practices as they must adjust to this more relaxed attitude toward work in the practice.

This combination of factors inevitably leads the present physician leadership of many smaller practices to seriously evaluate their choices. The retirement accounts of many physician practice leaders have been decimated by the recession and financial crisis. Physician leaders also face enormous potential liability from regulatory compliance issues, while professional liability is an ever-present threat. Finally, some new employees do not appear to share the same desire to take on major practice responsibilities. Thus, these cultural changes are a significant factor in pressuring physicians to make difficult choices.

3. The development of integrated systems

Historically, physicians have operated a cottage industry populated by thousands of solo practices or small groups. In 1991-1997, 40.7 percent of physician practices were solo or two-physician practices. At that time, 61.6 percent of physicians owned an interest in their practice.[8] Only 16 percent of physicians practiced in groups with more than six physicians, and 10.7 percent practiced with hospitals.[9]

In June 2013, 22.5 percent of physicians were in solo or two-person practices, while 17.6 practiced in groups of three to nine physicians.[10] In December 2015, these numbers declined to 19.8 percent and 15.5 percent.[11] From July 2012 to July 2015, the percent of hospital-employed physicians increased by almost 50 percent, with the number of employed physicians increasing to

7 Historically, Medicare and private payers have created a compensation model that reimburses hospital-based outpatient surgical services at a greater rate than outpatient surgical services. This differential has been limited recently as all new hospital-based out-patient services ae reimbursed the same as nonhospital-owned ASCs. The justification for this differential is the need of hospitals to support greater infrastructure that stand above out-patient centers since hospitals provide a wide range of services and provide care to uninsured patients.

8 "Proportion of Physicians in Solo/Two Physician Practice Groups," Center for Studying Health System Change, Aug. 16, 2007; http://hschange.org/CONTENT/942/?/PRINT=1.

9 Liehafer and Crossman HSC Community Tracking Study Physician Survey, Tracking Report 18, August 2007.

10 David B. Muhlestein and Nathan J. Smith, Physician Consolidation: Rapid Movement From Small To Large Group Practices, 2013–15 Health Affairs 35, no.9 (2016):1638-1642.

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more than 140,000.[12] A survey of residents indicated that 36 percent of residents preferred to be employed by a hospital than any other job option.[13]

This trend has been predicted for years. It is no secret that many of the most respected health care economists in the United States believe that integrated systems are the best structure to reduce health care costs. Influential policymakers such as Alain Enthoven and Uwe Reinhardt strongly advocate integrated delivery systems as a solution to the health care cost issue.

It is also of little dispute that the federal regulatory policy in the past has been designed to push physician groups into integrated systems. As discussed earlier, so many of the regulatory moves to limit ancillary services available to physicians have developed loopholes or exceptions for hospital-owned groups. Thus, there is no compliance issue with a physician-employee of a hospital referring a patient to the hospital for imaging. However, if the physician referred the patient to a shared imaging center, this could result in a violation of federal law.

Value-based payment structures as created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) are designed to push physicians into larger groups.[14] Only the larger physician organizations can realistically perform the analysis necessary to become an Alternative Payment Model with a chance to obtain higher reimbursement.

Another factor driving integration is current antitrust enforcement policy, which allows clinically or financially integrated provider systems of networks to negotiate with plans, whereas physician groups operating without the requisite level of integration cannot.

Finally, the push to acquire and implement electronic health records also appears to favor larger systems. The cost of electronic health records may be out of reach for many small physician groups, notwithstanding Medicare or Medicaid "meaningful use" incentives.

4. Health care reform

The culmination of this inexorable governmental and policy push toward integrated delivery systems is reflected in the ACA. The ACA calls for the development of multiple pilot projects, virtually all designed for integrated systems. These pilot projects encourage episodic payment systems such as bundling, capitation and quality payments, as well as medical homes and other collaborative programs. In addition to these pilot projects, there is a specific statutory provision authorizing the creation of accountable care organizations (ACOs). These are, by definition, integrated delivery systems requiring one entity utilizing participation from providers of all types necessary to deliver complete health care services to Medicare patients. ACOs, if successful, will receive a percent of any cost savings generated by the ACO in caring for the Medicare population assigned to the ACO, notwithstanding the long-standing federal gainsharing prohibition.

In the build-up and aftermath of health care reform, it is apparent that the development of integrated delivery systems are a goal of the federal government, and that, as a consequence, such systems will continue to develop and become a large part of the health care delivery system.

5. Lack of capital

Given this impetus for the development of large, integrated delivery systems, many physicians would like to participate as equal partners in the development of these systems. However, the infrastructure essential to the development of these systems requires substantial financial resources. Unfortunately, physician practices have not been structured to develop capital resources or to serve as vehicles for raising capital. Hospitals and insurance companies typically are the only types of players in the health care market that have access to the capital that is needed to develop these integrated delivery systems. Consequently, as physicians are pressured to move into larger systems, it can be very difficult for them to self-finance this growth.

6. Shortage of physicians

The number of physicians per capita will decrease in the United States because physician production has not kept pace with population growth. Further, the number of elderly will double because of baby boomers and longer life spans. In addition to more elderly, medical successes across the life span have resulted in more people living with serious and chronic illnesses (e.g., cancer survivors, AIDs patients). Finally, even the best prevention will not

12 Physician Practice Acquisition Study: National and Regional Employment Changes, September 2016, accessible at http://www.physiciansadvocacyinstitute.org/Portals/0/PAI-Physician-Employment-Study.pdf

13 Merritt Hawkins, 2015 Survey of Final-Year Medical Residents, accessible at https://www.merritthawkins.com/uploadedfiles/merritthawkings/surveys/2014_merritthawkins_fymr_survey.pdf.

14 42 U.S.C.A. §1395-4(f).

eliminate disease but only delay it. Indeed, this shortage is already becoming apparent, particularly in primary care. According to a 2016 study by the Association of American Medical Colleges, there is a projected shortfall in primary care physicians ranging between 14,900 and 35,600 physicians by 2025, and a projected shortfall in non-primary care specialties ranging between 37,400 and 60,300 by 2025.[15]

This physician shortage should be a countervailing factor in the continual decline of physician income. Logically, if physicians are in short supply, there should be an increase in the compensation payable to them in order to attract physicians. So far, because of the highly regulated Medicare fee structure, this rebound in physician income has not occurred. However, it is hard to believe that incomes can continue to decline in the face of severe shortages. Paraprofessionals may be utilized to plug some of the gaps, but they cannot substitute for physicians in most situations due to the vast differences in education and training. In any event, the shortages are so great it seems impossible for it not to have a positive impact on physician incomes.

When one steps back and surveys the environment in which physicians are operating, it is fair to state that physicians are facing one of the most complex situations ever seen by any professional group. In the face of these pressures, it is hard for physicians to conclude that they should stand pat. On the other hand, the correct choice does not seem all that clear either. Nevertheless, common wisdom would indicate that the trends described above are going to continue. Smaller practices will likely be at a disadvantage in almost everything, from reimbursement to cost to capital to hiring. The entities capable of creating the administrative and logistical infrastructure to develop integrated delivery systems will likely become increasingly dominant in the market. Those organizations able to deliver large numbers of physicians to these integrated delivery systems will be at an advantage. On the other hand, the existing and growing shortage of physicians should put many physicians in an advantageous position. For example, ACOs must have primary care capacity under the reform bill. Primary care physicians are at a premium. Their numbers are small and are diminishing. This should mean that they will be able to demand greater income and more benefits from ACOs and other integrated delivery systems. Similarly, other specialties may find themselves in the same position in a short period of time. Cardiologists are becoming rare. Neurosurgeons are always in demand.

Understanding that all of these factors complicate physician decision making, it is useful to at least examine some of the options available to physicians at this point.

Options

There are so many possible scenarios. The hypothetical at the start of this chapter is only one. The situation will be much different for a physician in a small rural area or specialists in a large single-specialty group. A large multi-specialty group will also have a different situation. Much will depend on the number of hospitals in the physician's locale. The possible circumstances are virtually endless. However, as a prelude to the rest of this Physician Guidance, the following is a list of some of the options available to physicians, which will be expanded upon in later chapters.

1. **Don't do anything.** This is certainly a possibility for some physicians in unique situations. For example, physicians specializing in in vitro fertilization may be able to continue to practice as they have been because of their unique market, which is driven by patient choice. Other physicians may prefer to continue on in small practices. A larger specialty group that has not seen substantial reductions in compensation may be able to watch and wait. A large multi-specialty group may have enough leverage in a particular market to stay independent while demanding support from integrated delivery systems. However, it is very hard for a group to stand pat when so many groups are selling or consolidating. The psychological pressure can sometimes be more than the actual financial concerns.

1. **Stand pat but attempt to grow the practice.** One fact that seems to be clear even in the muddled situation that we face is that larger will often be better. Consequently, a smaller group of physicians that is not under immediate financial pressure can continue its present course but attempt to grow by adding physicians or merging groups. Whatever the payer—insurance company, ACO, medical home, Medicare, Medicaid—there will be a need for physicians to provide the services. If the medical group is of substantial size and can deliver a substantial number of physicians to the payer, the group will generally be in a better position to negotiate rates and document its quality. This larger size will allow the group to be more flexible as it adapts to whatever may come in the future.

15 The Complexities of Physician Supply and Demand: Projections from 2014 to 2025, 2016 Update, Association of American Medical Colleges, accessible at https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf.

2. **Employment by hospitals.** This may be a way for many physicians to eliminate substantial administrative responsibilities while aligning with the hospital system that can provide the infrastructure to be able to compete in a world increasingly dominated by integrated delivery systems.

3. **Form large clinically integrated practice associations** that can negotiate as one. As such, these large clinically integrated systems may be able to provide substantial numbers of physicians to the various integrated delivery systems, such as ACOs or hospital-integrated systems. By doing so, the individual physician groups could remain largely independent and negotiate as one to seek better positions in these integrated delivery systems, both in terms of control and reimbursement.

4. **Changing to a concierge or direct practice.** This method of practice will, in all likelihood, still be viable after the insurance reform provisions of the ACA take effect. People may be willing to pay for personalized care beyond their insurance premium. As long as this type of practice methodology is not outlawed, it certainly may remain a viable option.

5. **Partnering with hospitals.** Physician groups may be able to develop service-line management companies by which they can retain some independence but receive compensation from the hospitals for providing management services of a specific service line within the hospital. Another example is to utilize the medical staff relationship with the hospital to try to develop a partnering structure for ACOs or integrated delivery systems. This will be dependent upon the attitude of the local hospital.

6. **Partnering with health insurers.** Physicians may also want to consider arrangements with health insurers to obtain the capital and data necessary to operate an ACO. This scenario may allow physicians to reduce hospitalizations without the potential pushback of a hospital partner. However, the success of such a venture will depend on the willingness of the health insurer to cede significant control to the physician group.

7. **Sell or merge with venture-based consolidations.** Many investment bankers have significant investments in companies that are seeking to consolidate physician groups in order to build nationwide groups able to effectively negotiate with payers and build value-based organizations. These venture organizations have been most effective with hospital-based specialties such as anesthesiology and pathology. However, they are also active in other specialties. It is important for any group considering its options to learn what venture options exist in its specialty.

In analyzing and evaluating these various options, physicians will have to be very objective and candid about their situation in the market.

- If you are a solo practice in a large city, you will have to recognize that your ability to continue in that practice will likely depend on your willingness to take reduced income or switch to a concierge-type practice. However, your ability to secure a beneficial employment agreement with the hospital may be limited as well, depending on your specialty.

- On the other hand, if you are a small practitioner in a small town, your importance to the local hospital may give you the clout to secure a strong relationship with the hospital, potentially without becoming a hospital employee. If that hospital is going to be able to deal with integrated delivery systems or insurance companies, it is going to need your allegiance and support. The hospital may threaten to bring in a competing doctor, but that may not be a real threat given the shortage of physicians.

- If you are in a position where you might be able to develop a large clinically integrated organization, you must understand that that is going to cost substantial amounts of money, time and resources. It is not something that can be undertaken lightly. Therefore, if you want to commit to developing such an organization, you must make sure that the resources are available to help you complete your efforts.

- You may be a substantial multi-specialty group. In that case, you may want to consider potential hospital partners that recognize your value. You may be able to develop a relationship with a hospital partner that allows you to maintain a substantial amount of your autonomy while giving the hospital what it needs with your participation in its integrated delivery system. Alternatively, there may be a health insurer that is interested in affiliating with you and providing significant capital and technological resources.

In making an assessment of options, it is very important to be extremely realistic about your group's strengths and weaknesses. These are some of the questions that need to be asked:

1. Is your group on sound financial footing, and can you continue to sustain reasonable incomes over the next five to six years?

2. Is your group going to invest in some of the infrastructure—both technological and human—that will be needed to compete with more sophisticated integrated delivery systems?

3. Does your group have strong and deep leadership with cohesion among the members? If you don't have both of those characteristics, staying the course may be difficult.

4. Who are the realistic partners you might work with, and how trustworthy are they? There are differences between hospitals, medical groups, and investment banker options in their reliability and credibility. When you can, it is better to partner with a reliable party rather than one who offers more money at the outset but cannot be counted on to stay the course.

5. What is your bargaining position in the community? Are you well-thought of, and do you bring sufficient capacity to give you substantial leverage? If not, it is important to evaluate what kind of leverage you might have and how you might strengthen it.

6. Is your group prepared to spend the time and resources it will take to carve out a strong position in any joint venture such that the group or the physicians in it will have a substantial say in that new, combined organization? It will take time and money to put your group in a position where it will have a substantial say in any organization, be it an ACO or integrated delivery system. If the group doesn't want to spend that time and money, it is probably best not to reach too high for a leadership position.

7. What is your plan for the future? Are you close to retirement or in the prime of practice? If the former, you may want to try to obtain the best money deal possible. If the latter, you may want to choose a partner for the long-term. This difference in perspective can create difficulties between members of the same practice when making group decisions.

8. If you want to test the market, spend a substantial amount of time considering your alternatives. Consider hiring a consultant such as a valuation company or an investment banker to help you evaluate your options. Understand that the money you will receive as part of a sale will be recaptured by your purchase by reductions in your compensation. There needs to be some benefit to your group other than the one-time payment. The most important question for the group is "Can this buyer help us survive the next ten years with reasonable comfort?"

As indicated earlier, the scenarios can go on ad infinitum. The choices are difficult and the clear answers few. Hopefully, this "how-to" manual will give you some idea on how to deal with your specific circumstances.

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