

Can Solo Practitioners and Small Group Practices Survive in Today's Challenging Marketplace?

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The simple answer is "yes," but they will have to make substantial changes in the way they do business. This means that more than ever, they will need to think "outside the box."

While practicing medicine has never been easy, today's physicians must struggle with difficult issues that physicians in prior generations never had to address. As a result, physicians still clinging to the traditional model of practicing alone, or in small groups, must fight to survive as operating costs mount, reimbursements decrease, governmental oversight expands, and third-party audit initiatives become more common. Because of these pressures, contemporary physicians are, in increasing numbers, abandoning traditional notions of medical practice and seeking to operate within new business structures that allow them to better compete in today's healthcare market. Others are simply closing their private practices and entering into employment agreements with local hospital systems that have begun to actively recruit more and more physicians by encouraging them to "walk away" from the uncertainties and pressures of private practice in exchange for a steady salary and job security.

Problem #1: Increasing Operational Costs

Increases in costs have given impetus to physicians considering new practice configurations. One escalating cost is malpractice liability insurance premiums, which have not only increased significantly in the last few years, but show no sign of abating in the near future. Malpractice insurance, though, is just one of the rising costs physicians must withstand. Physicians are also faced with rising office expenses. This includes the sizable expense of drugs necessary for in-office procedures, which becomes increasingly more burdensome as drug prices continue to increase at rates significantly in excess of inflation. Contemporary physicians must also pay higher salaries and fringe benefits for their office staff than did their predecessors because such positions now entail more sophisticated work due to the increasingly complicated nature of health insurance.

Problem #2: Decreasing Third-Party Reimbursement

Cost increases, however, are not the only thing driving physicians to consider practice restructuring. Decreases in third-party insurance reimbursement is also contributing to the growing trend whereby doctors are either joining together into larger groups, or abandoning private practice completely and electing to become hospital employees. If Congress fails to pass legislation to change the antiquated and flawed formula which the 1997 Balanced Budget Act mandates that the Medicare Program use to annually compute physician reimbursements, then physicians will likely continue to see their Medicare revenues decrease.

Rate cuts in the Medicare program are particularly troublesome to physicians because private payers (such as managed care companies) frequently use Medicare rates as their benchmark when negotiating their own payment rates. If Medicare rates

decrease, or even stay constant, it becomes difficult for physicians to negotiate increases in their payments from private payers. Adding to the difficulty of negotiating for higher fees is the fact that private health insurance payers are growing larger and more powerful through insurance company mergers. As these private payers grow in size, they begin to attain greater power and control in the marketplace. An April 2006 American Medical Association (AMA) study found that in fifty-six percent of the 294 metropolitan regions studied, a single health insurer controlled fifty percent (50%) or more of the private payer market. The former president of the AMA, Dr. William Plested, stated that this growth in the market power of private insurers "has left physicians with little leverage against unfair contract terms. In short, as private payers grow, physicians' bargaining power is diminished, and they are forced to either accept the private payers' low rates, or lose a large portion of their businesses."

Problem #3: Increasing Governmental Regulations and Audits

Recent actions by both the federal and state governments have imposed substantial new challenges on solo practitioners and small group practices. Among the most imposing of these is the federal government's attempt to expand electronic health record (EHR) implementation by threatening to cut Medicare reimbursements for those who fail to adopt and "meaningfully use" EHRs by 2015. This initiative is part of a larger plan to link future Medicare reimbursements to clinical integration and quality of care (rather than to fee-for-service). The cost of purchasing and implementing a "certified" EHR system for many solo practitioners and small group practices is overwhelming and is a major reason why many such providers are looking for alternative practice arrangements at this time.

Other governmental regulatory initiatives in recent years which are both costly and daunting to solo practitioners and small group practices include new requirements involving HIPAA privacy compliance, identity theft compliance, office-based surgery accreditation, and MRI/CT/nuclear medicine accreditation.

Budgetary constraints at both the federal and state levels of government have also led to new initiatives to audit the billing and coding practices of healthcare providers, and, where appropriate, to demand monetary refunds from them. In this light, it is expected that Medicare's Recovery Audit Contractors (RACs) will greatly increase their visibility in this and future years by performing more unscheduled on-site visits to provider locations and initiating widespread Medicare claims audits. Similarly, Medicaid Integrity Contractors (MICs) will likely continue to increase their Medicaid audits. In fact, on March 10, 2010, President Obama issued a mandate requiring all federal agencies (including the US Department of Health and Human Services) to expand their use of Payment Recapture Audits to root out improper payments.

These audit initiatives are separate and apart from the fraud and abuse investigations which are continuing to increase on both the federal and state levels. Such investigations seek to identify those healthcare providers who are engaged in inappropriate "self-referral," or "kickback" arrangements with other healthcare providers who refer patients to them.

All of this heightened governmental oversight of medical practices imposes a significant new cost on solo practitioners and small group practices who must shoulder the burden of establishing comprehensive compliance plans and hiring experienced compliance personnel to assure that they and their staffs are conducting their business operations in a lawful manner.

Problem #4: Increasing Audits by Private Insurers

The dramatic success which federal and state investigators and auditors have had in recouping money from healthcare providers in recent years has not gone unnoticed by the private insurance industry. Managed care companies are devoting more and more resources and personnel to identifying physicians and other healthcare providers who have allegedly been overpaid by them (through upcoding schemes, inadequate medical record documentation, or by providing services which are not deemed to be medically necessary) and demanding large (and immediate) repayments from them. As a result, physicians are under greater pressure than ever to make sure that their billing staff is conversant with all of the complicated rules and regulations that govern each carrier's unique claims processing protocol and that all physicians in their practice understand how to document their medical records properly. The expense and difficulties that go hand-in-hand with such billing and coding compliance, and the related costs associated with defending oneself against such insurance company audits, are putting even more pressure on solo practitioners and small group practices.

The Movement toward Practice Consolidations,

Multi-Specialty Groups and Other New Arrangements

Option #1: Joining With Others to Form A Larger and/or More Diverse Group Practice

Through combining their medical practices, physicians have sought to gain more negotiating leverage with private payers, reduce their operational overhead through economies-of-scale, and increase their revenues by retaining referrals within the larger group that would otherwise be sent "out the door" to specialists who are unaffiliated with the group.

While a private payer can afford to drop the services of one small practice from its plan, it generally cannot afford to drop a large practice that provides a substantial percentage of a particular professional service within a given geographic area. A simplistic example, ignoring possible antitrust implications for the moment, illustrates how combining practices can increase physicians' bargaining power with insurance companies. If ten cardiologists operate offices in a 15-square-mile area, then the dominant health insurer in that area can dictate rates to each of the cardiologists because if one chooses not to accept its rates, the plan can simply drop him or her and rely on the other nine physicians in that geographic area to provide cardiology services to its members. If, however, the ten cardiologists combine their practices into one large practice, then the dominant health insurer must negotiate rates with that large group practice because if both parties cannot agree on acceptable rates, the health insurer will not have a provider of cardiology services for its members in that geographic area. In essence, if a physician combines his or her practice with other medical practices, the resulting practice will have a greater market share which may afford it significantly more leverage when it negotiates its rates with private payers.

Practice consolidations also allow physicians to reduce their operational expenses through economies-of-scale. While each of the ten cardiologists in the example above may have needed two full-time staff members to handle their individual insurance paperwork, the combined ten-physician practice might only need a staff half that size in order to deal with the same level of

paperwork. Similarly, while each separate cardiology office likely needed its own photocopier machine, the combined office would presumably need far fewer photocopiers. The same goes for electronic medical records (EMR) systems, medical equipment such as EKG, ultrasound, and x-ray machines, and professional support services, such as those provided by lawyers and accountants.

Practice consolidations, particularly those involving physicians in different specialties, also allow physicians to expand the scope of services which they provide "in-house" and in doing so, enable them to retain revenues within their new group that are attributable to professional services that would otherwise have been referred "down the block" to other practitioners or groups with whom they have no professional or business arrangement.

Patients themselves may also benefit from medical practice consolidations. A 2006 study found that "patients in larger-volume groups are more likely to receive higher-quality care than those in lower-volume groups." The study also found that more integrated practice structures that include "centralized decision-making and closer physician affiliations" provide higher-quality care to patients. Thus, another benefit of practice combinations is that they may actually increase the quality of care offered to patients.

Physicians can enjoy the benefits of restructuring through a number of different business structures. A traditional merger of one group into another group is one option. Here, the physicians merge one of their practices into the other practice. As a result of such a merger, one professional entity takes over the other (i.e., with the acquiring entity surviving), but as a larger group than it was prior to the merger. Alternatively, the two groups can consolidate and form a brand new entity with a new name and identity.

Regardless of how the merger is legally structured, the physicians should consult with an experienced healthcare attorney for advice on various aspects of the transaction. For example, a significant amount of due diligence will be required to make sure that each party understands the assets and liabilities that it may be inheriting as a result of the merger or consolidation.

Similarly, there will need to be a substantial effort to effectively coordinate retirement plans, insurance policies, fringe benefit programs, office and equipment leases, bank loans, etc. The new group will also require a new governance structure which will dictate how decisions within the larger practice entity are to be made and new "buy-out" arrangements that address how the group will handle the transfer of equity interests by deceased, disabled, or retiring physicians. The physicians may also want to include a "bail-out" clause in their merger or consolidation agreement. A "bail-out" clause allows the merged parties to "undo" the merger during an initial period of time (typically, the first few years) if either party is unhappy. The physicians may also want to clearly identify which party will be responsible for certain liabilities that arose prior to the merger. This is usually done through some sort of indemnification provision in the merger or consolidation agreement.

Federal and state laws may also require the physicians to notify their patients and administrative agencies of the practice reorganization.

Option #2: Joining An Existing "Mega-Group," or Forming a New "Mega-Group"

Another business structure that is being used more frequently to combine physicians' practices is the integrated, multi-specialty "mega-group," which offers a middle ground between the complete practice integration of traditional mergers and consolidations and the loose integration of IPAs. Such "mega-groups" allow their physician-members to continue to practice medicine from the same office that they did prior to joining the "mega-group" and with the maximum degree of autonomy that is legally permitted under the Federal "Stark" Law. These "mega-groups" developed from an earlier, but now discredited, model known as a "group without walls." These new "mega-groups" have integrated their clinical operations into a unified business in order to avoid being classified by governmental authorities as a "group without walls." In so doing, they will be viewed as something more than just a "loose confederation of independent practices" or an "informal affiliation of physicians" which the government could arguably allege was improperly formed for the primary purpose of sharing profits from patient referrals. Such "groups without walls" have historically lacked centralized management, clinical integration, and other attributes of a unified business, and as such, are not viewed as being "true" group practices, which is what the Federal "Stark" Law requires in order for physicians within the group to freely (and legally) refer patients to one another for "Stark-covered" services. In essence, these "mega-groups" set up a quasi-franchisor/ franchisee arrangement. Each physician is, in effect, a franchisee of the "mega-group," with each office site being a satellite office (and separate profit center) of the "mega-group." This allows physicians to maintain some degree of autonomy in how they practice medicine while also being able to: (a) negotiate with private payers as a large integrated group practice without worrying about violating price-fixing regulations; and (b) meet a statutory exception to the self-referral restrictions set forth in the Federal Stark Law.

Just as with physicians who engage in a traditional merger or consolidation, physicians seeking to form, or join, a "mega-group" should consult with an experienced healthcare attorney for advice on all of the various issues and concerns that need to be analyzed and negotiated to make sure that the new initiative is not only legal, but achieves all of the goals that led them toward such a dramatic change in their practice structure. For example, it is important that the physicians who practice at the various office locations which are maintained by the overall "mega-group" have internal agreements among themselves which address those practice-related issues that are still within their operational control as well as those pre-existing understandings that address how the death, disability, or retirement of a physician at that office site will be handled by the other physicians at that site.

Option #3: Forming an Independent Practice Association (IPA)

Traditional mergers or consolidations are not the only means by which solo practitioners and small group practices can retain their autonomy and remain in their own private practices while at the same time, acquiring negotiating power with managed care and other insurance companies. In recent years, physicians have also been forming independent practice associations (IPAs). An IPA is an organization of independent physicians that join together to facilitate contracting with private payers. Under this arrangement, the physicians typically maintain their own practices and create a new legal entity (i.e., the IPA), which negotiates with private payers for the physician-members of the IPA. Historically, some physicians have preferred this arrangement over a

traditional merger or consolidation because it gives them increased bargaining power in negotiating fees with private payers while enabling them to still enjoy the autonomy of a solo or small group practice.

The IPA must be carefully structured by experienced healthcare attorneys since such organizations are subject to a higher level of antitrust scrutiny by governmental regulations. The Federal Trade Commission (FTC) has stated that the physicians in an IPA must either share financial risk, or clinically integrate, in order for the entity to comply with antitrust laws. Thus, when an IPA negotiates capitation contracts for its physicians, its actions are within the bounds of the law. If, however, the IPA begins to negotiate fee-for-service contracts for the group, then the physicians in the IPA will most likely be forced to clinically integrate in order for the entity to remain in compliance with antitrust laws. This is because the FTC views IPAs that negotiate fee-for-service contracts for their members as engaging in price-fixing arrangements, which is a violation of Section 1 of the Sherman Anti-Trust Act. The FTC takes this view because it sees the physicians in an IPA as competitors of one another (unless, of course, they are sharing financial risk, or are clinically integrated). Thus, as capitation contracts have become less common and fee-for-service contracts have become more prevalent, physicians in IPAs have had to clinically integrate their practices in order for their IPAs to remain legal. Such integration makes the IPA structure less attractive because it requires physicians to sacrifice a substantial amount of their autonomy (and this desire to retain maximum autonomy was historically the primary advantage of the IPA structure over other practice-combination structures).

If a group of physicians decides to create an IPA, they should consult with an experienced healthcare attorney to ensure that their practices are sufficiently integrated to comply with antitrust laws. This is especially so because the FTC "looks for evidence of processes, standards and controls that would limit costs and improve quality in the provision of network services" when determining whether an IPA is clinically integrated. The difference between an IPA that is sufficiently integrated to comply with antitrust laws and an IPA that is not sufficiently integrated remains ambiguous. Thus, legal counsel can be helpful in determining what "processes, standards, and controls" must be implemented in order to form an IPA that operates within the bounds of federal and state antitrust law.

Conclusion

Rising expenses, decreasing revenues, increasing governmental oversight, and new audit risks have made maintaining a viable solo, or small group, practice more difficult than ever. Physicians, however, can survive in this tough market through practice restructuring that is clearly thought-out and strategically planned with the assistance of competent and experienced healthcare advisors. Restructuring does not necessarily require that physicians sacrifice all of the autonomy that they have enjoyed in the past. Physicians can still continue to enjoy their independence through new and creative business structures that are a proactive reaction to the difficult marketplace which exists today.