

PHYSICIANS ASSEMBLE!

INTEGRATING SMALL GROUPS TO PRESERVE INDEPENDENT PRACTICE



IN THE FACE OF INDUSTRY CONSOLIDATION AND EMPLOYMENT, SMALL PRACTICES ARE JOINING FORCES TO CONTROL THEIR OWN DESTINIES AND REMAIN COMPETITIVE.

DAVID TWIDDY

Consolidation has firmly gripped the medical industry with thousands of physicians shutting their doors or selling their practices to hospitals or large groups. Last year, the consulting firm Accenture estimated that only about a third of U.S. physicians would remain truly independent by the end of 2013 compared with 57 percent in 2000.¹ While some dispute these estimates, it's hard to deny that there has been some movement toward physician employment. Professional recruiting firm Merritt Hawkins said 63 percent of its physician search requests in 2011-2012 came from hospitals, compared with 45 percent in 2008-2009.² And The Advisory Board Company estimated that 40 percent of active pri-

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mary care physicians worked for a hospital in 2012, double the percentage in 2000.³

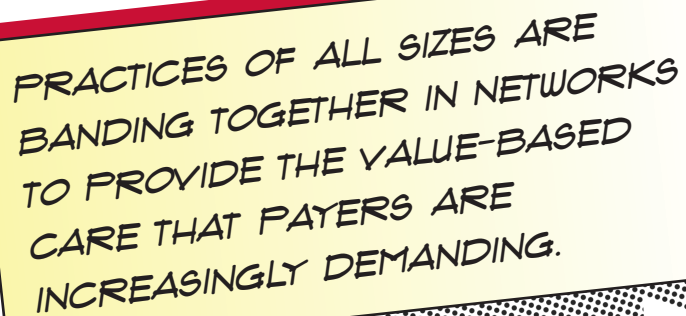
The changing financial model for health care has led many physicians to leave independent practice, and hospitals and health care organizations are snapping up primary care practices to realize greater economies of scale and deeper pools of resources.

Not all independent practices are disappearing, of course. But those wanting to remain independent must deal with these same financial pressures – and possibly use the same solutions of their larger competitors. This article examines how primary care practices of all sizes are banding together in networks to provide the value-based care that payers are increasingly demanding. These networks typically involve some level of clinical integration while still allowing practices to exert control over their own businesses.

Clinical integration involves five main areas:

- Fully engaged physician leadership,
- Evidence-based patient care management,
- A comprehensive system for monitoring the effectiveness of the group as well as the individual physicians,
- A way to share patient data across the care continuum,
- A strategy for communicating costs and patient outcomes with the payer community.⁴

Integrated networks can have some or all of these features, depending on how closely the member physicians want to work together, what issues they're trying to address in their local medical community, and whether



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their competitive strategy triggers legal or structural requirements for greater integration.

Integrated groups that seek greater negotiating power with payers may be subject to review by the Federal Trade Commission or Department of Justice to ensure they are not violating antitrust statutes.

Some key models for integrated groups have emerged (or re-emerged) in recent years. Below are descriptions of those models, as well as examples of practices that have adopted these models to improve their competitive position.

The unified back office

A management services organization (MSO) typically provides business leadership and support services for a group of practices, allowing the member practices to focus on the clinical side of their offices. MSOs may be owned by physicians, investors, a hospital, or all of these via a joint agreement.

Premier Family Physicians in Austin, Texas, formed an MSO in 2009 when the six physicians in the group's core practice grew concerned over the future of health care and their shrinking reimbursements from insurers.

Managing partner John K. Frederick, MD, said they determined collaboration with their fellow family physicians was necessary, and they began approaching other physicians in the community to join them.

Premier employs a separate CEO to run the business and charges members a fee for billing, a call center, and other back-office support services. They share a unified brand, but the members have remained in their original locations and kept a level of autonomy over their hours, work spaces, and employees. ➤

PRACTICE INTEGRATION TIPS

Find like minds: The seed of any integrated group is a shared concern between physicians and a belief that collaboration is the best possible solution. These connections can be made at state medical conferences or simple meetings within your local community. The first step is to start talking.

Reflect the macro: Any potential group needs to evaluate what's going on in its community in terms of hospitals acquiring primary care practices and payers implementing accountability and value-based payment systems – and how well prepared the group and individual practices are to meet new challenges.

Mind the store: Informal groups may get by with regular meetings to discuss strategy and share operational knowledge and advice, but groups that are actively negotiating with payers or are expected to track cost and care metrics will require more professional management. Group members who have business experience could fill this position, or the group could hire a full-time CEO.

Don't break the law: The Federal Trade Commission (FTC) looks to ensure integrated physician groups are not engaged in anticompetitive practices that could ultimately raise health care costs. FTC's policy is available at <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm>.

Remain flexible: Given the evolving health care environment, groups may have to change their goals and even how they operate to succeed.

■ Small practices are pursuing a number of strategies to combine in ways that improve competitiveness but maintain some independence.

■ Management services organizations let practices focus on patient care instead of back-office tasks.

■ Some IPAs are signing up as ACOs or PCMHs to gain incentives and improve negotiations with insurers.

The group includes 16 “care teams,” or a single doctor in a practice working with a midlevel provider and several medical assistants. Frederick said this structure has allowed physicians to see more patients because they don’t have to deal with some of the more mundane tasks of the visit, and it lets them do a better job of tracking each patient’s progress. The number of care teams is expected to grow after a large multispecialty practice joined the MSO this summer, boosting the number of primary care physicians to around 70.

The original 16 teams were required to use the same electronic health record (EHR) program. Frederick said this was a tough sell for some physicians, but the group has worked to show how using a single EHR can improve profits and coordination of care. With the addition of the new group, with its own EHR, the organization is looking for programs that allow the two systems to speak to each other.

He said having the ability to show care metrics for the 80,000 patients that the member practices cover has led to increased leverage in discussions with area insurers and a partnership with one of the city’s two main hospitals.

A new kind of IPA

A well-established model for the integration-minded physician has been the independent physician/practice association (IPA), a partnership of solo physicians or group practices that uses its size to realize economies of scale in purchasing or contracting with managed care organizations. Depending on how the IPA is structured and managed, member

physicians may have a great deal of autonomy in their own practices, although some IPAs are more like corporations with CEOs and other executives.

The IPA model has gained new currency as some are signing up as accountable care organizations (ACOs). This opportunity was provided for in the Affordable Care Act and provides incentives for medical practices that provide low-cost, high-quality care to a specific group of patients, such as Medicare recipients.

Depending on how the ACO is structured, its members can share in any savings they generate in the care of patients. Having a more centralized management structure can help to meet the increased reporting requirements for ACOs.

Still another option for IPAs is the patient-centered medical home (PCMH) model. This practice style, which may require certification, is designed to provide better care coordination, better access, and higher quality through a closer partnership with the patient. Like the ACO, the PCMH has the potential of attracting attention and more favorable pay rates from insurers.

Neither approach is mutually exclusive. In fact, it could be argued that an effective ACO should have member practices that operate as PCMHs, and vice versa.

The Kansas City Metropolitan Physicians Association was formed as an IPA in the fall of 2011 to unify the city’s fragmented independent practices and help them gain attention from commercial payers and hospitals. Neither changed their response to physicians, however, largely because they said the association, now with 210 physicians in 41 practices, had no track record as an organization and couldn’t provide data showing how the IPA was improving patient care and health care costs.

So the group changed strategy. More of its member practices adopted the PCMH model to boost care coordination. Although the practices don’t share a common EHR system, the group is working with Kansas City-based software maker Cerner Corp. on a health information exchange to extract cost and quality data from the individual practices.

The IPA took the added step earlier this year to form a Medicare-certified ACO that will receive enhanced payments from the Centers for Medicare & Medicaid Services to help the smaller primary care practices add the

KEY QUESTIONS TO ASK BEFORE INTEGRATING

Geography: What market or markets do you want to cover?

Size: What is the optimal size for your model to succeed in your market?

Investment: What infrastructure do you need to buy now to protect your future revenue stream?

Legal: How should you structure your group to avoid anti-trust issues?

Independence: How much independence are you willing to give up for the planned clinical and business integration?

Culture: Is this group the right fit for you and your employees?

Flexibility: How adaptable is the planned organization to changing circumstances, and can it make needed changes quickly?

technology and other infrastructure needed to track and improve patient care. The ACO will also use the money to hire a dedicated CEO, care coordinators, additional registered nurses, and other professional staff.

Under Medicare rules, only the group's 71 primary care physicians and midlevel providers can participate in the ACO.

Even before forming the ACO, the member practices were clinically integrated in terms of having shared quality improvement measures, performance measures, and evidence-based guidelines, all of which the members developed through regular committee meetings.

Group founder Nathan Granger, MD, MBA, said he was surprised by how many independent physicians have resisted joining the group, often because he couldn't assure them of an immediate boost in revenue or profit. He said groups need to acknowledge that the financial benefits of integration are farther down the road but also take into account the potential problems that practices will encounter with payers if they don't belong to an IPA, ACO, or other group in the future.

"It's a strategy, not a 'get rich quick' process," Granger said.

Key Physicians in Raleigh, N.C., is an IPA that was formed in 1994 so that member practices could better manage capitation contracts. When capitation was phased out in North Carolina, the group decided to stick together.

The IPA now includes 225 primary care physicians in 61 locations. In recent years, it has remodeled itself to attract more attention from self-funded employers and health plans by requiring all of its member practices to adopt the PCMH model, even agreeing to pay their application fees and providing consultants to assist in the process.

The IPA uses the messenger model, meaning it acts as a conduit for insurance contracts with the individual practices as opposed to negotiating on their behalf, which would violate antitrust rules. But executive director Ray Coppedge said it is working toward becoming more clinically integrated and being able to negotiate as a single network. In the meantime, the IPA is using cloud-based technology to allow the 10 EHRs being used by its member practices to communicate and coordinate care with local specialists.

Coppedge said Key Physicians is still small compared to some of the health care groups

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in the region. But he said the ability to show that its practices are having an effect on patient lives and health care costs is resonating with self-funded employers.

"Size and might has been the big stick," he said. "Quality and value is the new stick."

Coppedge said Key Physicians' decision in 2010 to rebrand the IPA as a medical home network helped lead to a collaborative ACO contract with Cigna for 16,000 covered lives and another one with Blue Cross Blue Shield of North Carolina for 28,000.

He added that being part of the network provides its physicians with added revenue, the improved efficiency and reach of having care teams, and an entrée into the future of value-based payment.

The decentralized medical group

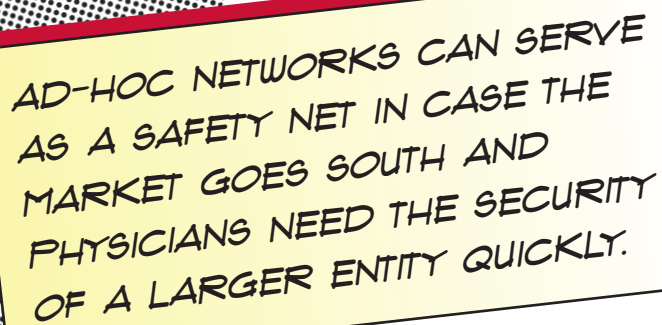
In some cases, the IPA model may not provide enough integration to suit a group of practices' needs and they end up forming a new unified group practice. Physicians sacrifice independence for employment in return for greater stability and a better negotiating stance with payers.

Decentralized group practices come in different configurations, and some have looser connections than others. For example, Vanguard Medical Group, formed in 2011, combines 22 physicians into a regional primary care group in three communities in northern New Jersey. While essentially a merged practice, the three offices retain some independence. In fact, two locations are part of separate ACO agreements, and one is involved in the Comprehensive Primary Care Initiative, a CMS-led multipayer effort that provides enhanced payment for participants. The three locations have their own EHRs, but

Persuading physicians to join IPAs or ACOs can be difficult if they're looking for an immediate boost in revenue or profits.

Cloud-based technology can help practices with different EHRs communicate and share health information with each other.

Forming a decentralized medical group means losing some independence but gaining the safety of size.



AD-HOC NETWORKS CAN SERVE AS A SAFETY NET IN CASE THE MARKET GOES SOUTH AND PHYSICIANS NEED THE SECURITY OF A LARGER ENTITY QUICKLY.

■ Practices in integrated groups can share best practices and resources and experiment with new ways to do things.

■ Rural physicians have a hard time integrating because of distance – but can realize big benefits in cooperation and dealing with insurers.

■ Physicians can also form loose groups with limited integration as a hedge for the future.

they share information through an online disease registry. They have integrated their clinical processes through clinical and administrative dashboards that measure performance, and they share some senior-level administrative staff and a quality improvement specialist. The main goal is not financial savings but improving and quantifying outcomes with an eye to attracting performance-based contracts.

Robert Eidus, MD, the group's president, said so far the biggest benefits of forming the group have been hiring care coordinators and using the shared disease registry to quantify and improve their care metrics. They also learn best practices from each other, experiment with new ways of doing things, and share resources, such as a psychiatric nurse practitioner who now rotates between the offices throughout the week to improve patient access to mental health services.

"I think that [integration] has given us a sense that we have a more stable long-term structure and we have more strategic and tactical options," he said.

The rural IPA

Given the sparse patient populations and often great distances between them, rural physicians face added challenges when it comes to integrating into larger groups.

Physicians in southeast Nebraska formed the South East Rural Physicians Association (SERPA) in the 1990s, initially intending the IPA to help small, rural practices get on more equal footing with their counterparts in more populated areas as managed care began to ramp up. The IPA also served as a source for continuing medical education for both employed and independent physicians in the area.

One of the founders, American Academy of Family Physicians president-elect Robert Wergin, MD, said the first step to forming groups like this may be attending a state meeting and finding like minds among other rural physicians. Once the core group is formed, you can decide whether you want a low-key group to discuss common concerns or a more formal group dealing with accountable care and payer issues.

This year, the association formed a Medicare ACO, which many rural physicians can't do by themselves because they're too small and spread out, Wergin said.

SERPA includes 118 physicians, of which 48 are participating in the ACO. Still, the ACO is large enough that members expect to benefit through shared-savings arrangements with insurers.

"With SERPA one of the advantages is you don't have to feel alone," Wergin said. "We're part of a bigger organization that can help you identify problems and come up with solutions."

Clinical integration has been limited among the SERPA practices, although they share CME resources and patient satisfaction survey procedures. Wergin said the move to an ACO will require more coordination, especially in terms of technology, and SERPA has applied for and received state and federal grants to help transition more practices to EHRs and create an online information exchange.

The ad hoc group with an "exit strategy"

Of course, the easiest path to take is the one you're already on. For a variety of reasons, some physicians value their independence over forming or joining groups.

This means they'll have to face changes in reimbursement, growing market pressure, and increasing infrastructure needs by themselves, even as they deal with the continual siren call of hospital employment.

But there are creative ways to keep the shingle above the door while also gaining some "strength in numbers." For instance, physicians often collaborate informally with their colleagues through curbside consults or trading management tips over coffee or social events. In some cases, those collaborations give rise to informal networks that provide substantive benefits to their members through group purchasing.

Such networks also can serve as a safety net in case the market goes south and physicians need the security of a larger entity quickly.

James Cunnar, MD, is a solo family physician in suburban Chicago who hasn't yet seen a need to enter any formal groups. But he and three other solo physicians jointly purchased an EHR system several years ago.

He said the joint EHR helps the four physicians run their individual practices more efficiently and improve care. But he said it also means if they ever decide the market is turning against independents like themselves, they'll have one of the most difficult and expensive aspects of merging already out of the way.

They meet quarterly to review their respective operations and discuss whether they've started to see any push-back on reimbursement, which Cunnar said would be an early warning that they need to move forward with their master plan of unifying their practices.

But he said the biggest lesson he's found from the group is to focus on patient care and not get too overwhelmed by the nitty gritty. Good care will increase patient visits and revenue, and that won't change, he said.

"It makes us feel a little more secure to have each other if we need each other," Cunnar said.

Although these integration models vary widely in terms of their size, how they operate, and the level of

independence their physicians enjoy, each group reflects a unified belief in the value of medicine practiced outside the control of hospitals and large health care systems. The long-term financial and operational success of these groups, in many cases, is still unknown and could change dramatically as the landscape of health care continues to shift. But for most of the individual physicians and practices, teaming up is offering them the best possible option for facing those challenges and providing their patients with the care they deserve. **FPM**

1. *Clinical Transformation: New Business Models for a New Era in Health-care*. Arlington, Va.: Accenture; October 2012.

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4. Grauman DM, Graham CJ, Johnson MM. Five pillars of clinical integration. *Healthc Financ Manage*. 2012;66(8):70-77.

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Mead Johnson "Doctor's Office A Century Ago" Exhibit at AAFP Headquarters. 1975-1984, from CHFM photo collections.

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