SURVIVAL OF THE FITTEST

A REVIEW OF PROMISING MODELS FOR THE MAINTENANCE OF INDEPENDENT PRIVATE MEDICAL PRACTICE

A Report to The Physicians Foundation

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Table of Contents

About The Physicians Foundation

The Physicians Foundation is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and help facilitate the delivery of healthcare to patients. As the U.S. healthcare system continues to evolve, The Physicians Foundation is steadfast in its determination to strengthen the physician-patient relationship and assist physicians in sustaining their medical practices in a difficult practice environment.

The Foundation participates in the national healthcare discussion by providing the perspective of practicing physicians on the many issues facing them today. This includes identifying how The Patient Protection and Affordable Care Act and other aspects of health system reform impact physicians, and what should be re-assessed or changed in order to achieve the following goals:

- Provide physicians with the leadership skills necessary to drive healthcare excellence
- Offer physicians resources to succeed in today's challenging healthcare environment
- Understand evolving practice trends to help physicians continue to deliver quality care to patients
- Meet the current and future needs of all patients by assessing the supply of physicians

The Physicians Foundation pursues its mission through a variety of activities including grantmaking, research, white papers and policy studies. The Foundation provides grants to nonprofit organizations, universities, healthcare systems and medical society foundations that support its objectives and, since 2005, has awarded numerous multi-year grants totaling more than $28 million.

The Physicians Foundation also examines critical issues affecting the current and future healthcare system by periodically surveying physicians and patients, and studying the impact on them of government healthcare policies. The Foundation believes that as America evaluates significant changes in healthcare, the perspectives of practicing physicians and their patients must be well-understood and addressed.

For more information, please visit www.PhysiciansFoundation.org

Executive Summary

In our 2008 report to the Physicians Foundation on the state of independent medical practice in this country, we concluded that "many of the nation's small independent medical practices are struggling, caught between falling revenues and rising costs, with no leverage to negotiate a better deal for themselves." Four years later, it appears that the stream of physicians leaving private practice for employment has become a torrent. This report reviews recent trends and the current status of private practice, the major challenges facing private practices, and some of the new models and strategies that innovative private practice physicians across the country are using to survive, and even thrive, in today's increasingly turbulent health care environment. The report concludes with recommendations for key stakeholders.

Recent trends

The two most recent national physician surveys to look at practice ownership were conducted four years ago, one by the American Medical Association, the other by the Center for Studying Health System Change. Both found that approximately three out of five physicians were sole or part owners of their practice, a proportion that was on a par with findings from a previous AMA survey conducted in 2001. While no comparable national physician surveys have been conducted since that time, it appears from a variety of sources—including physician recruitment data, site visit reports from a dozen representative markets across the country, and the views of industry insiders and other health care experts active in the field—that in the four years since those surveys were conducted, the pace of physician employment has picked up dramatically. For example, Merritt Hawkins reported that in 2010/11, 56 percent of its physician search assignments were for hospital positions, up from 23 percent in 2005/06, and the Center for Studying Health Systems Change was told by local health care leaders in the Greenville-Spartanburg market in South Carolina that approximately 90 percent of physicians in Greenville and 60 percent of physicians in Spartanburg were now employed by hospitals. Similar findings were reported in eight of the eleven other market areas that the Center's staff visited.

While the enactment of national health reform in 2010 may be contributing to these trends, the primary drivers appear to be the growing financial pressure that many private practices are experiencing as their costs increasingly exceed their revenues, coupled with stepped-up efforts by large hospitals and health systems to enhance their negotiating leverage through provider consolidation, including the acquisition of physician practices.

Challenges

Revenues have been declining for many smaller independent practices because they lack the leverage to negotiate more favorable reimbursement rates with the two or three major payers who dominate their markets. The recession has added to their woes in recent years

as patients have put off non-essential care and collections have fallen behind, and cuts in Medicare payments for certain office-based procedures and drugs have taken an additional toll, particularly among specialties such as cardiology and oncology. Meanwhile, the "hassle factor" of dealing with increasingly burdensome insurer requirements and government regulations has intensified, while costs for staffing, benefits, malpractice coverage, and office operations have continued to rise—including substantial outlays for new technologies such as electronic medical record systems.

When Merritt Hawkins asked physicians in 2008 how satisfied they were with their practice, only 34 percent of those who responded to the survey said they were "satisfied" or "very satisfied." Given the challenges that they have faced over the past four years, it would not come as a surprise if the number were even lower today.

Survival tactics

In response to these mounting pressures, many physicians have opted for employment and some have simply battened down the hatches until they can retire in a few years. But others, who want to remain in practice and retain their independence over the longer haul, have adopted a variety of strategies to strengthen—or in some cases, completely redesign—their practices. Specific steps that can shore up an existing practice include everything from contracting out billing and collections and collecting copayments and deductibles at the time of service to reducing and cross-training administrative staff, computerizing the practice (which may, but doesn't necessarily, include an electronic medical record system), employing midlevel providers, and adding new revenue-generating services.

In addition, joining independent practice associations or mergers with other independent practices can provide greater negotiating leverage with hospitals and payers, as well as with vendors, but may involve some loss of autonomy and control over the practice. Finally, for those physicians seeking a more fundamental restructuring of the conventional private practice model, micropractice and concierge medicine offer some interesting ways for them to be able to spend considerably more time with their patients—in a micropractice, by keeping overhead costs to an absolute minimum; in a concierge practice, by charging an annual feel that enables the physician to keep the number of patients relatively low.

The key takeaway from these strategies and models is that there is a range of financially viable options that allow physicians to remain in private practice and achieve a high level of personal satisfaction in their practice, even in today's very challenging health care environment.

Summary and recommendations

Based on our review, we conclude that while it is indeed possible to survive and even thrive in private practice in the current environment, business as usual is not an option. Serious steps must be taken to adapt to the new realities, and implementing these steps may well take some physicians outside of their comfort zones. Moreover, it may well be in the financial interest of those who pay for health care to provide the support necessary to maintain private practices, in order to slow hospital-system consolidation that will otherwise continue to drive costs through the roof.

Specifically, we recommend that:

1. A major outreach effort should be initiated to inform practicing physicians (and medical students and residents) that robust models of private practice exist that are viable, sustainable, and professionally rewarding, even in today's health care environment.
2. New models of private practice should be supported, tested, and disseminated as they emerge.
3. Payers should be encouraged to increase their support for private practices, so that those practices are not absorbed by large hospital systems seeking to further increase their negotiating leverage.
4. A new national physician survey should be fielded as soon as possible, preferably in a way that will make it compatible with past surveys.
5. Focus group and survey research should be conducted to determine the public's level of awareness and concern about what is happening to private medical practice.

We close with the observation that while the traditional model of private practice may no longer be viable in today's rapidly changing health care environment, the same pressures that are driving these practices out of business are also giving rise to innovative new models and approaches that could well represent the leading edge of the next generation of private practice. We are therefore cautiously optimistic that private practice will, for the foreseeable future, remain a vital and vibrant part of the nation's health care delivery system.

Survival of the Fittest: A Review of Promising Models For the Maintenance of Independent Private Medical Practice

A Report to The Physicians Foundation

Isaacs/Jellinek
April 3, 2012

Purpose

In a 2008 report for the Physicians Foundation on the state of independent medical practice in this country, we reached a sobering conclusion: "Our review of the existing research literature, together with our interviews with thoughtful observers in the field, makes it clear that while some independent practices are still thriving—particularly procedure-based specialists in single-specialty groups—many of the nation's small independent practices are struggling, caught between falling revenues and rising costs and with no real leverage to negotiate a better deal for themselves. What's more, most of the observers we interviewed were not at all optimistic that the outlook for those practices was likely to improve in the coming years, short of dramatic changes in current reimbursement policies." [i]

Four years later, it appears that the stream of physicians leaving private practice for employment has become a torrent. In some communities, independent private practices have practically disappeared, as growing numbers of established physicians have either retired or sold their practices to hospitals or health systems and many young physicians just entering the workforce have opted for the security of employment rather than taking a chance on private practice.

Opinions on how much this matters vary. Some observers welcome the trend towards larger health systems as an opportunity to improve the quality and cost-effectiveness of care, but others—including many practicing physicians—are deeply troubled that the accelerating collapse of private practice is jeopardizing what they view as the very

foundation of American medicine: the doctor-patient relationship.

Building on our earlier report, this report reviews: (1) recent trends and the current status of private medical practice; (2) the major challenges facing private practices; and (3) some of the models and strategies that innovative private practice physicians across the country are using in order to survive, and even thrive, in today's increasingly turbulent health care environment. The report concludes with recommendations for some of the key parties that have a stake in these developments.

For the purposes of this report, we use the term private practice interchangeably with independent practice, which we defined in our earlier report as a practice that is owned by the physician or physicians who work there (although such a practice may also include salaried physicians, as well as other salaried providers). We are particularly interested in smaller private practices, although we also consider larger practices and networks of private practices that collectively may include a much larger number of private physicians.

Recent Trends

The two most recent nationally representative surveys of practicing physicians that included questions about practice ownership now date back four years: the American Medical Association's 2007-2008 Physician Practice Information (PPI) Survey, and the 2008 Physician Survey conducted by the Center for Studying Health System Change (HSC).[*] Both surveys focused on non-federal physicians who were actively providing patient care for at least 20 hours a week, and both found that, as of 2008, more than half the nation's practicing physicians were still in private practice—that is, they were owners or part owners of the practice where they worked. Specifically, the figure from the AMA's PPI Survey was 61.1 percent,[ii] five percentage points higher than the HSC finding of 56.0 percent.[iii]

[*] Although both surveys were conducted in 2008, the findings did not become available until the following year, after our 2008 report on the status of independent medical practice.

Somewhat to our surprise given earlier downward trends in private practice, the AMA's 2007-2008 figure of 61.1 percent was essentially the same as the 61.5 percent reported seven years earlier in its 2001 Patient Care Survey[iv] (the 2008 HSC survey results cannot be directly compared with earlier HSC surveys due to a change in survey methodology).[v] Perhaps this apparent plateau in practice ownership between 2001 and 2008 reflects the fact that, after aggressively buying physician practices during the 1990's in anticipation of managed care, many hospitals later reversed course and jettisoned those same practices as it became clear that most managed care plans would not be using physician gatekeepers to control costs.

Given the recent resurgence in hospital purchases of physician practices, it is worth noting—as a kind of benchmark—that in its 2007-2008 PPI Survey, the AMA found that at that time, just four years ago, only about one in six practicing physicians (16.3 percent) was employed by a hospital, while just under half of all practicing physicians (46.0 percent) were either in solo practice (24.6 percent) or worked in small groups of two to four physicians (21.4 percent). Not surprisingly, however, the proportion of those who were employed by hospitals was almost twice as high among physicians under age 40 (22.3 percent) as it was among those age 55 and older (11.9 percent). What *is* somewhat surprising is that, although the proportion of solo practitioners was much higher among physicians age 55 than among physicians under age 40 (36.2 percent versus 13.6 percent), the proportion who worked in small groups of two to four physicians was actually higher among physicians under age 40 (25.6 percent) than among physicians age 55 and older (17.4 percent).[vi] If this pattern were to hold, it could mean that while the solo practitioner may become an increasingly rare breed in the years to come, small groups may actually stage something of a comeback—provided that they don't get scooped up by hospitals or other large health systems.

So what do we know about what has happened to private practice since 2008? Unfortunately, there have been no nationally representative surveys looking at practice ownership since that time, despite the fact that these past four years have been a period of

dramatic change in the nation's health care system, including the enactment in March 2010 of the Patient Protection and Affordable Care Act (ACA). Although the ACA is not scheduled to be fully implemented until several years from now, and although it still faces some major legal and political hurdles—including a Supreme Court ruling on the constitutionality of the individual mandate and a presidential election later this year—its impact is already being felt as the health care system begins to reposition itself in anticipation of a whole new set of rules and incentives.

One indication of the changes taking place is a report from Merritt Hawkins, a major national health care search and consulting firm, that "56 percent of [its] physician search assignments in 2010/11 featured hospital employment of the physician, up from 51 percent the previous year and up from 23 percent in 2005/06." In explanation of this surge in physician recruitment by hospitals, Merritt Hawkins observed that "physicians are seeking stability of employment, while hospitals are seeking to align with physicians in response to health care reform, which is promoting the use of Accountable Care Organizations, bundled payments and other physician-aligned and integrated delivery systems." [vii]

Health care experts we spoke with concurred. Michael Ziegler, a prominent health care attorney in New York City who represents medical practices, told us, "The trend toward larger practice groups and hospital practices is inexorable," while Larry Wolper, a leading physician practice consultant, observed that "the prospects for independent practice are very bleak." And Dr. Joel Klompus, president Brown & Toland, a large independent practice association in the San Francisco Bay area, told us, "We've seen the trend toward hospital employment continuing, and it has changed recently. Before, hospitals were looking to employ physicians from tertiary and quaternary specialties. Now, hospitals are putting together networks of more regular physicians, such as primary care physicians."

A striking example of how this national trend has been playing out at the local level was described in the Community Report on the Greenville-Spartanburg metro area in South Carolina issued by the Center for Studying Health System Change (HSC) in February 2011. "In the last three years [2008-2010], the Greenville Hospital System University

Medical Center [GHS] has increased the number of employed physicians from about 160 to more than 550," the report states. "GHS now employs five times the number of physicians employed a decade ago and projects additional hires in the coming years. Spartanburg Regional now employs about 270 physicians, up from about 180 physicians three years ago. Spartanburg Regional also owns 51 percent of a clinically integrated physician hospital organization known as Region HealthPlus [which lists almost 500 physicians on its website]." The report goes on to say that "several respondents estimated that about 90 percent of physicians in Greenville and 60 percent in Spartanburg are now employed by hospital systems." [viii]

According HSC, which conducted intensive site visits in 12 nationally representative metropolitan areas across the country during 2010, what has been happening in Greenville-Spartanburg is not an isolated case. In an issue brief from August 2011 summarizing the findings from its site visits, HSC reported that "while not new, the pace of hospital employment of physicians has quickened in many communities, driven largely by hospitals' quest to increase market share and revenue... And, while hospital employment of physicians is more pronounced in areas with higher levels of hospital consolidation—for example, Cleveland, Greenville, Indianapolis and Lansing—it is also taking place in less consolidated hospital markets, such as Seattle, Little Rock, Phoenix, Syracuse and Miami." In only three of the markets that HSC looked at—Boston, northern New Jersey, and Orange County, California—was the pace any slower, in Orange County because of a state law prohibiting hospitals from directly employing physicians and in Boston because physician organizations already "keep non-employed physicians tightly aligned with the dominant hospital system." [ix]

Looking ahead, the global management consulting firm Accenture surveyed hospital executives and other industry stakeholders in late 2010, several months after the enactment of national health reform, and issued a projection that "the rate of independent physicians being employed by health systems will grow by an annual five percent over three years. By 2013, less than one-third of physicians are expected to remain truly independent." [x] If this projection is borne out—and data from places like Greenville-Spartanburg suggest that it

may not be too far off the mark—it will represent a staggering decline in private practice in this country: in just the five years since the AMA's 2008 PPI Survey, the proportion of physicians who are full or part owners of their practice will have been cut almost in half, from 61 percent in 2008 to less than 33 percent in 2013.

Although the prospect of national health reform may have accelerated this downward spiral, it is important to bear in mind that private practice has been in decline for many years now. In our 2008 report, we calculated that over the previous 25 years, independent practices had already been declining at an average annual rate of roughly 2 percent, as younger physicians, including a growing proportion of women, have increasingly opted for the more predictable hours and reduced administrative burden that come with most salaried positions. And as HSC points out in its August 2011 issue brief, the dynamics behind the current surge in physician employment by hospitals are complex, largely predating the provisions of the ACA: "In return for admitting privileges, independent physicians historically served on the voluntary medical staff of one or more hospitals and performed such duties as on-call coverage and serving on hospital committees. But in recent years, several factors have weakened community-based physicians' ties to hospitals. Technological advances allowed more care to be performed in freestanding outpatient settings, leaving physicians less reliant on hospitals and less willing to take emergency call and sometimes directly competing with hospitals for lucrative specialty services. [In response,] hospitals started to employ specialists to cover on-call duties and increase market share for lucrative service lines, such as cardiac and orthopedic care, that they were in danger of losing to competing physicians." [xi] In addition, hospitals have hired more hospitalists who specialize in providing inpatient care, and they are now once again hiring primary care physicians—this time not as managed care "gatekeepers" but to ensure an adequate flow of referrals to their employed specialists. As one of HSC's Greenville informants commented, "There is a mad grab to hire primary care physicians." [xii]

While these dynamics help to explain why hospitals are hiring physicians, at the same time it appears that a growing number of physicians in private practice are turning to hospitals and other large health systems in desperation as they find themselves reaching the end of

their financial rope. Costs for everything from staffing and benefits to malpractice coverage and regulatory compliance keep going up faster than revenues are coming in, and most smaller private practices simply do not have the leverage to negotiate higher reimbursements from the two or three health plans that dominate their market. As the HSC report points out, "Hospitals usually negotiate health plan contracts on behalf of employed physicians, gaining higher rates to offer more attractive compensation than independent physicians could negotiate on their own." [xiii] Hospitals and health systems have not been not shy about pressing this advantage, as this fairly typical appeal to private physicians from the president of the NorthShore University HealthSystem Medical Group in Chicago illustrates: "From soaring costs to declining reimbursements to increased infrastructure requirements, physician compensation is under siege as never before. In this difficult environment, I am very proud that NorthShore Medical Group offers physicians highly competitive compensation, a slate of benefits that simply aren't available in most private practices, the security of a financially strong organization, and an infrastructure that supports ongoing practice growth. Collectively, these advantages have allowed us to attract and retain top talent across medical specialties." [xiv]

Thus, the recent surge in employed physicians—and the corresponding decline in private practice—has been fueled by the convergence, on the one hand, of a stepped-up demand for physicians by hospitals and other large systems seeking to expand their market share and, on the other hand, an increasing willingness on the part of financially stressed physicians to seek the economic shelter that employment in a hospital or health system appears to offer. And while, as an expert panel convened by Merritt Hawkins pointed out in a recent report to the Physicians Foundation,[xv] some of the "formal reforms" contained in the ACA may be raising the stakes for both sets of players, the important point is that these more fundamental "informal reforms" in both the hospital and physician sectors, which were already under way prior to the enactment of the ACA, will most likely continue to shape the future of physician practice in this country, irrespective of what happens to the ACA itself.

Could it all fall apart again, as it did in the late 1990's when hospitals relinquished many of

the physician practices they had acquired in anticipation of managed care? Most informed observers don't think so. Based on its interviews with hospital executives, HSC reported that hospitals have learned from their earlier experience: "Unlike the last wave of physician employment in the 1990s when salaried arrangements were common, hospitals today are using productivity-based compensation and [are] limiting purchases of practices' capital assets... Hospital respondents also noted they are now more selective about whom they employ, emphasizing that they don't buy practices 'for the sake of buying,' as they acknowledged doing in the 1990's, but rather buy on 'a stricter assessment of quality and service.'" [xvi] The expert panel convened by Merritt Hawkins reached a similar conclusion, and flatly declared in its report that "this time, reform will not be a 'false dawn' analogous to the health reform movement of the 1990's, but will usher in substantive and lasting changes." [xvii]

Challenges

In April 2011, the *New York Times* published a story about Dr. Ronald Sroka, a 62-year-old solo family physician in eastern Maryland, that begins with Dr. Sroka telling one of his patients about a recent fishing trip as he examines him, even though he's already running behind schedule and his waiting room is filling up. "Talking too much is the kind of thing that gets me behind," Dr. Sroka later admits to the reporter, "but it's the only part of the job I like." [xviii]

Dr. Sroka is not alone. Dissatisfaction among the nation's practicing physicians is widespread, as reflected in a 2008 physician survey conducted by Merritt Hawkins for the Physicians Foundation. Asked "How do you now find the practice of medicine?" only one out of three physicians (34 percent) responded either that it was "satisfying" or "very satisfying," while two out of three (66 percent) said that they now found the practice of medicine to be either "less satisfying" or "unsatisfying." Along the same lines, three out of five physicians (60 percent) indicated that they "would not recommend medicine as a career" to their children or other young people.[xix]

Like Dr. Sroka, when asked what they found most satisfying about medical practice, 50 percent of the physicians surveyed ranked "patient relationships" as the most satisfying aspect of their practice—the highest of any response—while only 3 percent rated "financial rewards" as the most satisfying aspect of their practice. Conversely, when they were asked what they found most *unsatisfying* about medical practice, reimbursement issues topped the list (ranked as "most unsatisfying" by 54 percent of the physicians surveyed), closely followed by managed care issues (52 percent), malpractice/defensive medicine pressures (50 percent), and Medicare/Medicaid/government regulations (46 percent).[xx]

But for many physicians, the problem goes beyond mere dissatisfaction. When asked what was his greatest concern about private practice, one specialist physician we spoke with, who is part owner of a single-specialty private group practice, told us bluntly, "Just its existence right now. In our city, the majority of the primary care practices are being taken over by the hospitals—and since the primary care doctors control the referrals, the hospital is controlling our practice." He indicated that "our revenues are down ten percent, and our expenses are up," and acknowledged that "we've talked with the hospital about the possibility of buying our practice." He added, "People aren't aware of how severe the pressure is." So what are some of the principal sources of pressure on private practice?

Declining revenues

In January 2011, the Texas Medical Association reported that in a survey of its members, three out of five (61 percent) indicated that their practice revenues had declined over the previous two years, and almost seven out of ten (69 percent) reported cash flow problems during the previous year due to "slow payment, nonpayment or underpayment of claims by insurers or government payers." Fully half of the physicians responding to the survey said that they were concerned about the continuing economic viability of their practices.[xxi]

According to a January 2012 story by CNN, the problem of declining revenues is by no means limited to Texas: "Doctors in America are harboring an embarrassing secret: many of them are going broke. This quiet reality, which is spreading nationwide, is claiming a wide range of casualties, including family physicians, cardiologists and oncologists." The story cites the example of Dr. William Pentz, a cardiologist with a private group practice in Philadelphia, who said that in 2011 he and his partners had to tap into their personal savings to make payroll for their employees. Their 2011 practice revenues were down about 9 percent from 2010, Dr. Pentz reported, in part because of steep cuts in Medicare reimbursement for office-based diagnostic procedures such as stress tests and echocardiograms.[xxii]

Along the same lines, the *New York Times*, in a March 2010 story titled "More Doctors Giving Up Private Practices," reported that Medicare reimbursements to cardiologists had been cut by "27 to 40 percent, depending on the type of practice," and noted that "in the wake of the government decision, cardiology practices across the country began selling out to health systems or hospitals." The story referenced an estimate by Dr. Jack Lewin, head of the American College of Cardiology, that "the share of cardiologists working in private practice had dropped by half in the past year." [xxiii] The sudden flight of cardiologists to hospitals was probably exacerbated by the fact that although hospitals also faced some reductions in cardiology reimbursements, their reimbursements were substantially higher than what private cardiologists were receiving for the same services. As Dr. Manoj Jain pointed out in the Memphis *Commercial Appeal*, when Medicare pays $450 for an echocardiogram done in a hospital and only $180 for the same procedure in a physician's office, for many cardiologists the motivation to throw in the towel and seek employment becomes almost overwhelming.[xxiv]

Cardiologists are not the only specialty physicians experiencing revenue reductions as a result of changes in federal payment policies. For example, as the CNN story points out, many oncologists, who are permitted to profit from drug sales, suffered a serious financial blow when Medicare reduced its reimbursements for many expensive cancer drugs below their actual costs, thereby making it nearly impossible for oncologists to derive any profit

from the sales of those drugs to their patients. A cancer center executive quoted in the story observed that "these physicians see no way out of the downward spiral of reimbursement, escalating costs of treating patients and insurance companies deciding when and how much they will pay them," and cited the case of one oncologist "with a sterling reputation in the community" who hadn't taken a salary from his private practice in a more than a year and owed the drug companies $1.6 million for which he hadn't been reimbursed.[xxv]

We should point out that these recent setbacks among certain private specialty physicians represent a departure from the finding in our 2008 report that procedure-based specialists in single specialty groups were largely doing quite well in comparison with many of their fellow physicians in private practice. Nor is it accidental: as the *New York Times* story points out, the Medicare savings in cardiology were intentionally "used to pay more to primary care doctors, widely seen as under great financial strain." [xxvi] And indeed, consistent with this shift in Medicare payment policy, some of the primary care physicians we spoke with in preparing this report indicated that their revenues had actually improved somewhat over prior years.

The recession

Recent reductions in Medicare payments like those affecting cardiology and oncology are part of the story behind declining practice revenues—and indeed Medicare cuts could potentially become a much bigger problem for many of the nation's practicing physicians if the federal government's Sustainable Growth Rate (SGR) formula, which hangs over American medicine like the Sword of Damocles, were ever to be implemented as originally intended. But Medicare is by no means the only reason that practice revenues have not kept up with costs in a growing number of private practices. Another reason that came into play since our last report has been the sharp downturn in the nation's economy following the financial meltdown of September 2008.

In February 2009, less than six months after the stock market collapse, the Medical Group Management Association (MGMA) reported on a survey in which nearly 70 percent of the responding physicians said either that their practice had already experienced a decrease in revenues or that there was a "considerable probability" of such a decrease occurring, while three out of four reported an increase in uninsured patients in their practice. In response, two out of three of the respondents had already cut their operating budgets and 59 percent had instituted a hiring freeze.[xxvii] A few months later, in May 2009, the American Academy of Family Physicians reported similar findings in a survey of its membership: 73 percent reported an increase in uninsured patients, 58 percent were experiencing more appointment cancellations, and 54 percent reported seeing fewer patients than before the recession.[xxviii] Dr. Jeffrey Luther, president of the California Association of Physicians, explained that "as people are tightening their belts, they are deferring things they think are a luxury or not absolutely necessary. We see people putting off physicals and mammograms and blood tests because they just don't have the cash." [xxix]

As anticipated by some of the respondents to the MGMA survey, it appears that the impact of the recession did in fact worsen the following year. A review of national health expenditures published in the January 2012 edition of *Health Affairs* indicates that total spending for physicians grew by only 1.8 percent in 2010, down from 2.5 percent in 2009 (and just barely above the overall inflation rate of 1.6 percent for 2010), a finding that the authors attribute to "a drop in physician visits because some people deferred going to see the doctor to reduce expenses and because the flu season in 2010 was less severe than in 2009." [xxx] The desire by patients to reduce their expenditures was probably exacerbated by the fact that, as the *New York Times* pointed out in its story about these expenditure data, "fewer people had private health insurance [and] insurers shifted some costs to subscribers, charging higher co-payments and deductibles." [xxxi]

An example of how the recession affected private practices is the case of Dr. Tanyech Walford, who was eventually forced to close her solo family medicine practice in Los Angeles after five years of operation. "I've watched revenues diminish because people can't, and are not, paying their bills," she told a radio interviewer in October 2008. "Last

year this time I had to refer maybe 2 percent of my patients to a collection agency to collect outstanding balances. Probably about 30 percent of my patients right now are referred to a collection agency. I don't like to put that kind of burden on them, but the flip side of the coin is that I can't pay my bills and I'm working for free." [xxxii] Her patients "began canceling in droves," including those who needed to be monitored for chronic conditions such as diabetes and heart disease. "Of those who did come in, many asked to be billed—even for co-payments as small as ten dollars—and then never paid." [xxxiii]

Similarly, Dr. Sroka, the family physician in eastern Maryland, saw his income plummet from a high of $324,000 in 2006 to only $97,000 in 2008 (although it did rebound somewhat, to $130,000, by 2010). As the *New York Times* noted, when he tried to sell his once-lucrative practice, he literally could not give it away.[xxxiv]

Rising costs

While practice revenues have been taking a beating, costs have continued to rise at a steady clip. Cost data from independent multispecialty groups collected by the MGMA indicate that practice costs have increased 50.9 percent from 2002 to 2011, compared with a 27.6 percent increase in the Consumer Price Index and only a 2.9 percent increase in Medicare payments over that same time period.[xxxv] Costs that were frequently mentioned in our interviews with practicing physicians include support staff salaries and benefits, technology, the costs of regulatory compliance, and malpractice coverage.

For example, Dr. Douglas Curran, a family practice physician in Athens, Texas, told us that two and a half years ago, his eleven-member group purchased an electronic medical record system for $300,000, plus another $200,000 for additional personnel. They made the purchase partly because "we can't get the young docs without it" and partly in order to stay current. However, Dr. Curran and his partners soon found that the EMR was substantially increasing the length of each patient visit because of the time that it took to enter all of the necessary information into the system. "So now we have a scribe for each doctor, which is

working out well," he said, but added, "The benefit is we can get the record quickly, but it's still a net negative financially." [*] (On the other hand, several of the solo practitioners we spoke with, who used their electronic medical record systems for billing as well as for clinical purposes, told us that the electronic medical record was a vital part of their office and that they would not have been able to operate and sustain their practices without it.)

Meanwhile, according to a recent report in *Modern Medicine*, medical malpractice costs have continued to rise, including both the cost of defending against a malpractice lawsuit—which rose 62.7 percent from 2001 to 2010—and the cost of medical liability insurance. In some parts of New York State, liability premiums for obstetrics/gynecology topped $200,000 in 2011, an increase of 41 percent since 2004, while premiums for general surgeons had jumped 64 percent since 2004, to almost $130,000.[xxxvi]

And the "hassle factor" has become a bigger headache than ever, according to almost every physician we spoke with. "You need prior authorizations for everything," a Virginia physician complained. A North Carolina physician lamented the inordinate amount of time that he and his staff had to spend fighting insurance denials, while a Rhode Island physician who started her solo practice in 2004 said that the single greatest change in her practice over the past eight years has been the relentless increase in the amount of paperwork due to insurance requirements. Her solution? "Now I have my patients call the insurance company for prior authorization. After all, it's their insurance company!"

Finally, the rising cost of support staff—which, according to MGMA, represented roughly a third (32 percent) of total medical practice operating costs in 2008—remains a very real issue for many private practices. [xxxvii] While some have tried to control these costs by eliminating raises and bonuses or even through pay cuts or lay-offs, this isn't always seen as an option. For example, Dr. Curran in Texas told us that for his practice, having the right personnel in place is "absolutely key" to survival. "The challenge," he said, "is to keep

[*] The same may be true at the health system level: a recently published study in *Health Affairs* found that "giving office-based physicians electronic access to patients' prior imaging and lab results did not deter ordering of tests," and concluded that "the use of health information technologies, whatever their other benefits, remains unproven as an effective cost control strategy with respect to the ordering of unnecessary tests."

them." Similarly, Dr. Neil Cohen, who said that staffing costs in his two-man family practice in Philadelphia, Pennsylvania, have continued to climb faster than the revenues have been coming in, told us that he and his partner have been absorbing the loss in order to protect and hold onto their staff: "It's coming out of our hides."

Size matters

Many of the challenges facing private practice are exacerbated by their relatively small size, which severely limits their negotiating leverage with payers, as well as their capacity to purchase electronic medical record systems and other revenue-enhancing or cost-saving technologies. Moreover, the absence of "deep pockets" means living closer to the edge, making it more difficult to ride out sharp economic downturns such as the recent recession. For example, Dr. Steven Ellison, a general internist in rural Ottumwa, Iowa, spent much his professional life in a small independent group practice of six to eight physicians, but it was a constant struggle. Ottumwa has a large Medicare and Medicaid population, which meant low reimbursement, and for those patients who had insurance, it became a hassle always fighting with the insurance companies. And so fourteen years ago, Dr. Ellison joined Iowa Health Physicians (IHP), a much larger 250-member group practice now in the process of merging with another group of about equal size, which will give it even greater clout with payers. "Working as a part of IHP has been wonderful," Dr. Ellison told us enthusiastically. "All I have to do is practice medicine and take care of patients. I don't have to worry about the business end—about billing, reimbursement, and record keeping. I get paid at standard RVU unit rates, even if I serve a Medicaid patient for whom the government pays poorly. And IHP keeps us legal, especially via electronic medical records."

On the other hand, some of the physicians we spoke with, including solo practitioners, actually viewed the small size of their practices as an advantage. "I can turn on a dime," a solo practitioner with only one part-time administrative staff declared. "I have no committees or any of that stuff to go through, so it's easy for me to adapt to changes in

insurance, or whatever comes down the road." David Gans, vice president for innovation and research at MGMA, agrees. "Small practices can be nimble," he says. "[They] have the opportunity to take advantage of concise governance. It's much easier to get the hearts and minds of all the owners and all the staff focused in the same direction if you're a small practice. If you can do that, you'll do well." [xxxviii]

Survival Tactics

This kind of agility—the ability to "turn on a dime" and adapt rapidly to whatever challenges today's turbulent health care environment may throw at them—may be one important explanation for why, despite the apparent hemorrhaging of private practices in recent years, private practice has by no means disappeared into the history books. Even if the Accenture projection cited earlier in this report is borne out that fewer than one-third of the nation's physicians will remain "truly independent" by 2013—which would, as we noted earlier, represent a precipitous decline from the 56 to 61 percent range reported in the most recent national physician surveys from 2008—there will still be some 250,000 physicians in private practice (based on a conservative estimate published in the *Journal of the American Medical Association* in 2009 that there are approximately 788,000 active physicians in the United States).[xxxix]

So how are these practices surviving, and in some cases even thriving? What are some of the survival tactics that physicians who still own their practices are using to hold onto them, and how well are those tactics working? Our interviews with some of these independent physicians and our review of the available literature—including news stories, blogs, and podcasts as well as more conventional sources—make it clear that there are no simple solutions, nor does one size fit all. The strategies and tactics that these practices are using are as varied as the physicians who run them and the communities that they serve. But the bottom line is that, at least for these physicians, they seem to be working, at least for now.

Independent Practice Associations

MGMA's David Gans believes that one strategic option for physicians who want to be or remain in private practice is to form or join and independent practice association (IPA). "In my opinion," he said in a 2011 interview for *Repertoire* magazine, "we'll see a resurgence of the IPA. It provides the opportunity for contracting and negotiating clout; it also offers the stability to sustain information systems on behalf of many of its doctors and to help the communication function. Doctors need electronic health records, but they oftentimes need that bridge [that the IPA can afford]. The IPA becomes the alternative option for the doctor to remain independent." [xl]

Not everyone agrees that an IPA is the answer. For example, in our earlier report, we noted the host of potential legal issues that, according to health care attorney Jeffrey King, need to be addressed in forming and operating an IPA, including licensure and choice of entity, illegal remuneration, HMO insurance regulations, self-referral, the use of utilization review agents, securities law, benefit plans, liability, and, in particular, antitrust provisions.[xli] We also cited the example of a Denver-area family physician who had joined an IPA and then complained bitterly about what he viewed as the loss of professional autonomy. As the story in the *Denver Post* observed, "It was bad enough for HMO's to try to tell him how to do his job. But when his own colleagues took over that role, it was intolerable." [xlii]

But for Atlanta pediatrician Norman "Chip" Harbaugh, who has been in practice for 23 years and whose pediatric group includes 13 physicians, two physician assistants and four nurse practitioners, the IPA model has been invaluable as a way to preserve his private practice—and with it, the doctor-patient relationship. "My basic premise," Dr. Harbaugh told *Repertoire* in 2011, "is [that] I want to preserve the physician/patient relationship." [xliii]

In 1997, Dr. Harbaugh and some of his fellow physicians formed a physician-owned IPA, the Kids Health First Pediatric Alliance, which today includes more than 200 pediatricians in some 35 practices. According to Dr. Harbaugh, the IPA has enabled the participating practices to cut costs on everything from malpractice coverage to vaccines while at the same time negotiating more favorable reimbursement rates with the region's payers. In

addition, the IPA has promoted the use of common forms and common treatment protocols among its member practices, and, as of 2011, was working on creating a physician-driven accountable care organization (ACO). As Dr. Harbaugh observed, "So now our organization has higher reimbursement and lower overhead. That allows me to stay in business, and I have more time to treat my patients better." [xliv] What's more, he told us, "We have a clinically outstanding practice—our clinical integrity comes first—and we doctors are the ones that control it. No doctor likes being told what to do by an insurance company or hospital administrator. If I worked for a corporate entity I'd be punching a time clock. We have maintained our autonomy." Dr. Harbaugh is currently in the process of expanding the concept of greater size and autonomy to the city of Atlanta and the state of Georgia.

In addition to the IPA, Dr. Harbaugh has been involved in setting up three more entities that take advantage of bigger size (what he calls "the Costco model") to support independent practices: (1) First Physicians Resource, a cooperative that is designed to provide a range of outsourced business services such as medical billing, health insurance review, and human resources administration to all physicians, not just pediatricians; (2) First Healthcare Payment Systems to handle credit card processing, collections and other financial services for physician practices; and (3) Kids Time Pediatrics to provide after-hours pediatric care by pediatricians (rather than by emergency rooms). "The IPA may be a little more work upfront," Dr. Harbaugh acknowledged in what may be something of an understatement. "But it's better than blindly selling to the hospital, which is hard to extract yourself from." [xlv]

While Dr. Harbaugh's Kids Health First IPA is based in a major urban area, the IPA strategy also appears to work for physicians in rural communities like Thomson, Georgia (population 6,828), about 130 miles east of Atlanta, where Dr. Jaqueline Fincher is a managing partner of a four-physician private practice that includes two internists (including herself) and two family practitioners (including her husband). Over the past six or seven years, the practice, MacDuffie Medical Associates, has been approached several times by hospital systems interested in acquisition, but so far, Dr. Fincher and her

colleagues have declined the offers. “The main reason is, we just really value our independence,” she explained in an interview with *Repertoire*. Like Dr. Harbaugh's pediatric group, Dr. Fincher's practice belongs to an IPA, along with some 90 other primary care physicians. And like Kids Health First, Dr. Fincher's IPA gives her practice added leverage in rate negotiations with payers as well as the advantages of group purchasing. And through networking with the other IPA member practices, it also enables her practice to keep abreast of the constant flood of new developments in today's rapidly changing health care environment. “We see the IPA as a godsend for us,” Dr. Fincher commented.[xlvi]

However, it is important to note that Dr. Fincher and her colleagues have not relied solely on the IPA to keep them afloat. Her husband, Dr. James Lemley, who has an MBA as well as an MD, works closely with their practice administrator to keep track of revenues and expenses, and they have networked extensively with other private practices around the country through the MGMA, a relationship that Dr. Fincher says “has been very critical for our practice.” In addition, almost everyone in the office has been cross-trained so that they can pinch-hit for one another as needed. And in order to help them retain their employees, who play such a critical role in the practice's day-to-day operations, Dr. Fincher and her partners redesigned the 401k retirement plan “to reward them for remaining with us.” [xlvii]

Practice mergers

While physicians like Dr. Harbaugh and Dr. Fincher have joined IPA's to help them preserve their private practices, others have gone a step further and have opted to formally merge with other practices in order to gain the advantages of increased scale, including greater leverage with payers and greater economies of scale. A typical story in the March 2011 *Greater Wilmington Business Journal* entitled “Medical Practices Merging to Survive” reported on small two cardiology practices in the Wilmington, NC, region that had recently merged to form Cape Fear Heart Associates, noting that “the practices that merged, formerly Wilmington Cardiology and Coastal Cardiology, total 16 doctors and 7 mid-level providers who specialize in comprehensive cardiac care.” [xlviii] On a somewhat

larger scale, the *Staten Island Advance,* in a story titled "Big Medical Merger on Staten Island Signals a New Strategy in Health Care," announced in December 2010 that "a merger between Staten Island Physician Practice and Victory Internal Medicine will give their patients access to virtually any medical service by creating a network of 75 doctors in a variety of specialties." [xlix] And earlier this year, in a story titled "Preserving Independence Through a Practice Merger," the Mississippi Orthopaedic Society told its members that "although health care reform, reimbursement changes, and continuing economic pressures are making hospital employment an attractive option, most surgeons still desire the autonomy of private practice. One option is to merge with other independent practices to create an organization with the scale and resources to thrive in today's health care environment." [l]

As the American Medical Association pointed out in its March 2008 Guidance on medical practice integration, the merger option "is not a new concept." Defining merger as "the consolidation of separate physician practices into one surviving medical group in which participating physicians have complete unity of interest," the Guidance went on to cite several prominent examples of successful physician practice mergers, including the Marshfield Clinic, the Mayo Clinic, the Cleveland Clinic and the Palo Alto Medical Foundation.[li]

But mergers do not have to be on the scale of a Mayo Clinic or a Palo Alto Medical Foundation in order to increase the market clout of the participating physicians. Randy Bauman, who specializes in physician mergers for Franklin, Tennessee-based consulting firm Delta Health Care, has pointed out that "a merger of even five or six doctors can create a significantly bigger force in most markets. It prevents the payers from playing one physician off against another." As an example of how physicians can get played off against one another, Bauman cites the following case: "I have a client in Idaho whose big payers have proposed a 50 percent reduction in some of their physician fees over the next three years. There are two groups practicing in my client's specialty in this market, and neither is stupid enough to agree to that payer proposal. But the payer knows that if one does not agree, the other will have to. So it becomes a divide-and-conquer strategy. The payer just

needs to find the price point at which one group will cave, and they win."[lii]

In addition to increased negotiating leverage, Pennsylvania health care attorney Todd Rodriguez has listed eight more potential benefits from physician practice mergers: (1) potential cost savings through economies of scale; (2) increased purchasing power; (3) the ability to offer ancillary services; (4) the ability to hire management expertise; (5) the ability to invest in information technology; (6) the ability to invest in compliance, risk management and billing/collection resources; (7) the ability to improve clinical quality through outcomes analysis, sharing of best practices and development of clinical practice guidelines; and (8) improved lifestyle through vacation and on-call coverage sharing.[liii] Small wonder, then, that Randy Bauman says that he has "seen interest in mergers make a huge resurgence recently."[liv]

Yet, like IPA's, "forming a large medical practice... is not without its difficulties," according to attorney Rodriguez, who notes that "depending on the size of the group to be formed and the range of services it will offer, there may be a host of legal issues including antitrust considerations and issues under the federal Stark and Anti-Kickback statutes." [lv] Nor are the challenges limited to legal hurdles. In a paper published in *Family Practice Management* more than a decade ago, Dr. Jeffrey Wilkins and his colleagues laid out the many issues that they confronted in merging six primary care practices with 14 physicians into a single group, TriValley Primary Care, PC, of Perkasie, Pennsylvania. Those issues included: (1) defining what organizational form their organization should take; (2) defining what the organization's mission and values should be; (3) preparing for the transition from six independent practices into a single unified group; (4) developing a strategic plan, including a detailed financial plan based on a careful market analysis; (5) developing the necessary partnership arrangements with other specialty groups, hospitals and payers; (6) arranging the necessary financing, which included a 10 percent withhold from each of the physicians' base salaries; (7) preventing potential coding and reimbursement problems that can occur when different practices are merged; and (8) communicating frequently and openly with employees during the transition and developing a comprehensive pay and benefits program.[lvi]

As Dr. Wilkins and his colleagues acknowledged, "Developing a successful medical group is hardly a quick or easy task. It requires careful planning, lengthy discussions and often difficult decisions. Our group spent more than a year in preparation, working through the… key issues." But almost four years after its 1995 launch, they declared TriValley Primary Care a "success story," with five additional physicians and three nurse practitioners, for a total of 22 providers practicing in five sites.[lvii] And today, 17 years after the initial merger, TriValley has grown to 29 physicians and five nurse practitioners, for a total of 34 providers practicing in seven sites along the I-476 corridor north of Philadelphia.[lviii]

At about the same time that Dr. Wilkins and his colleagues were forming TriValley Primary Care in eastern Pennsylvania, Dr. Al Hawks and some of his fellow physicians in High Point, North Carolina, were going through a similar process, with the help of the Delta Health Care consulting group. And just as many of today's mergers are being driven by financial concerns, so too were Dr. Hawks and his colleagues in the mid-1990s. "Although the dominant reimbursement model in High Point was fee-for-service," Dr. Hawks recalled in a 1999 article in *Family Practice Management*, "several of us (primary care physicians and subspecialists alike) realized that imminent changes in the health care delivery system were going to affect not only our financial futures, but our independence and level of control as well." To protect themselves and to preserve their independence, Dr. Hawks and his fellow physicians created a steering committee and developed a plan to form "a fully merged group of practices representing several specialties," and in 1995—the same year as TriValley—Cornerstone Health, comprised of 42 physicians in 15 practices, was open for business.[lix] Today, Cornerstone has grown to almost 300 physicians, physician assistants and nurse practitioners serving hundreds of thousands of patients throughout the Piedmont Triad region of North Carolina.[lx]

But despite these and many other successful practice mergers, Miami health care consultant Michael Casanova cautions that "there are many, many examples of improperly planned mergers and, sadly, break-ups with costly legal bills and shattered lives that litter

the landscape. Most of these pitfalls and eventual break-ups are the result of inadequate due diligence, and mostly the inevitable people issues that come along the way." [lxi] And perhaps even more fundamentally, as the AMA Guidance observes, "a merger is not for everyone," noting that "some physicians do not want to lose the degree of autonomy required by a merger." [lxii]

Micropractice

For those physicians who place a high value on professional autonomy, solo practice has traditionally been the option of choice. We spoke with a retired pediatrician, for example, who began his career in a five-physician group but struck out on his own when he realized that he "wasn't comfortable" with the compromises required within even a relatively small group practice. He spent the next twenty-five years of his career in solo practice—and loved it. "There's a special place of communication between the physician in private practice and the patient which is all about trust," he recalled. "The patient has to know that the doctor is acting in his or her best interest, and the doctor has to know that and feel that."

But as we noted in our earlier report, solo practice has been in steady decline, with the proportion of doctors in one- and two-physician practices dropping from 40.7 percent in 1995-96 to just 32.5 percent in 2004-05, according to the Center for Studying Health System Change.[lxiii] And the AMA, in its 2007-08 PPI Survey, found that only about one in four physicians (24.6 percent) was still in solo practice at that time.[lxiv] As Miami consultant Michael Casanova put it, "The waves of change are just too great to go it alone in a small boat. Anyone ever caught in a squall at sea knows that size does matter in turbulent times."[lxv]

Yet some physicians are deliberately choosing to go it alone in spite of the turbulence and in spite of the downward trend in solo practice. One such physician who has received considerable attention is L. Gordon Moore, a family physician in Rochester, New York, who took the leap into solo practice in 2001 after eight years as a staff physician at a large hospital-owned group practice. "To increase revenue, the hospital pressured him to see

more than 30 patients a day, usually for 15 minutes each," the *Wall Street Journal* reported in a 2007 profile of Dr. Moore. "Many patients couldn't get an appointment for weeks...[Dr. Moore] says he was so rushed he often failed to provide the best medical care, and once mistakenly prescribed a blood-pressure drug for a toddler." [lxvi] As Dr. Moore himself recalled in an article in *Family Practice Management*, "It seemed that all of the conversations in our office were about money. The only measure of success was 'revenue.' A good doctor, it seemed, was one with a high visit volume."[lxvii]

And so Dr. Moore bailed out, obtained a loan of $15,000, and launched what was truly a bare-bones "micropractice." No nurse, no receptionist, no lab, no waiting room, no dog-eared magazines—just a 150-square-foot exam room/office, some used furniture, a computer, and Dr. Moore himself. This new stripped-down micropractice model was a rather daring innovation, driven in part, as Dr. Moore acknowledges in his *Family Practice Management* article, by the seemingly prohibitive cost of establishing a more conventional solo practice from scratch, given the financial and regulatory realities of today's health care system. But as Dr. Moore points out, it was also driven by his decision to really focus in on the three paramount objectives that he wanted his new practice to achieve: (1) eliminating the barriers between the patient and the physician, (2) making sufficient time for meaningful interaction between the patient and the physician, and (3) investing in technology that would "put scientific and patient information at the physician's fingertips."[lxviii]

It appears that he was able to achieve these objectives. With overhead costs of only about 35 percent, compared with about 60 percent for other small primary care practices, Dr. Moore could afford to spend about twice as much time with each of his patients as he had in the large group practice. And when he surveyed his patients in early 2007, about 70 percent of those who responded said that they had received the care they wanted when they wanted it—compared with a national average of only about 30 percent.[lxix]

Dr. Moore, who has since moved to Seattle for family reasons, received a two-year grant from the Physicians Foundation to promote his micropractice model, and we spoke with

several other physicians around the country who have adopted the micropractice approach and established what are now referred to as "Ideal Medical Practices."[lxx] For example, Dr. Lynn Ho, a 52-year-old family medicine physician in North Kingston, Rhode Island, has no staff—just herself and a computer. She has been in business since 2004, has about 800 patients, and spends 30 to 60 minutes with each patient. Dr. Ho works 60 to 70 hours a week, which she acknowledged is probably more than most employed physicians put in, and like almost every physician we spoke with, she said that the ever-increasing paperwork burden was her greatest challenge. She acknowledged that primary care has been "under the gun" financially, but said that "this model is OK" and that she is making "the same or more" than she was three years ago. Asked to rate on a ten-point scale how much she was enjoying her practice, Dr. Ho laughed and said, "Clinically: 8 or 9—I love the practice of medicine. But administratively: 1."

Dr. Larry Lindeman, age 57, rated his satisfaction with his Chicago-based "ideal medical practice" an unqualified 10 on a ten-point scale and told us, "I'm having a really great time," although he added, "I imagine I'm in the minority." While he is the sole owner of his practice, Dr. Lindeman is technically not a solo practitioner: with some 2,400 patients, Dr. Lindeman employs a half-time fellow physician to work with him. Despite the large number of patients registered in his practice, Dr. Lindeman told us that he sees just 15 patients a day, and spends an average of 27 minutes with each of them. He said that the biggest change since he opened his practice in 2004 has been linking up with Advocate Health, an accountable care organization (ACO) in the Chicago area, which he said has increased his reimbursements by 30 percent. "We're doing really well," he told us, "and there's been no loss of autonomy with the ACO."

On the Outer Banks of North Carolina, Dr. John Haresch, age 43, has been operating a solo family practice for the past five years. Like L. Gordon Moore, he went into solo practice because of the relentless pressure for increased patient volume in his previous job, which in his case was at a community health center. Now he has only 650 patients and schedules 45 minutes for follow-up appointments. "The doctor-patient relationship is key for me," he

explained. He told us that by charging his patients a $75 annual membership fee and with only 0.75 FTE in administrative support, he is able to make ends meet, adding that his income needs are modest (he still drives a 1990's Civic). In addition, he noted that North Carolina Blue Cross-Blue Shield gave primary care physicians "close to a 20 percent boost" a few years ago, which has also helped to keep his practice in the black. Dr. Haresch has been updating his electronic medical record system in order to qualify for federal "meaningful use" payments, which he said will also help set him up to qualify as a "medical home." Rating his satisfaction with his practice a 7.5, he commented, "It would be a 10 if it weren't for the insurance hassles," adding with a laugh, "and some of the patients can be a challenge, too."

Up the coast in Newport News, Virginia, Dr. John Brady, age 46, launched his solo family medicine practice in Newport News, Virginia, in 2007, the same year as Dr. Haresch, and the following year was voted Virginia's Family Physician of the Year. With roughly 1,500 patients over the past two years, Dr. Brady has hired an LPN who handles the radiology preauthorizations, as well as a part-time RN to do patient education, even though patient education is generally not reimbursed. Like his fellow "micro-practitioners," his electronic medical record system is an indispensable part of his practice. "It allows me to practice in this way," he told us, "especially since I do my own billing." Dr. Brady is holding his head above water financially—in fact, last year was his best year yet—but he speculated that he may be making less money than if he had sold his practice to the hospital (adding, "but then I'd be seeing a lot more patients and probably burn out"). He said that he had considered converting to a concierge model in which his patients would pay him a flat annual fee, but decided against it. "People are already paying a lot for insurance," he observed, "so then they would have to pay even more." As it is, his patients get many of the benefits of a concierge practice, including same-day appointments for established patients; high continuity (they always see him); minimal to no waiting time; longer visits (20 minutes for established patients and up to an hour for new patients); home visits for patients in certain areas; and "24/7 access from one number with cell phone access when the office is closed."[lxxi] Dr. Brady rates his satisfaction with his practice at a 9 on a ten-point scale, although he, too, is feeling the growing administrative burden, with prior

authorization required for “just about everything.”

Concierge practice

While Dr. Brady decided against the so-called “concierge” model, a growing number of physicians view it as an attractive alternative to the high-volume, high-stress situation in which they are increasingly finding themselves. As one of Louisville, Kentucky, internist Mark Wheeler's patients told him, “Doc, do you realize your office is a lot like Disney World? It's a three-hour wait for a 20-second ride.” [lxxii] That was before Dr. Wheeler and his partner, internist John Varga, made the conversion to a concierge-style practice, called OneMD, that offers its patients 24/7 access to their doctor, customized health advice, a comprehensive annual physical, same-day service with no waiting, guidance with specialty care and any out-of-office testing or procedures, and “housecalls and visits to your office if necessary.” What made this high level of personal attention possible is that each physician in the practice (there are now three, with the addition of internist Paul Loheide) limits his practice to no more than 300 patients. As their website puts it, “On average, most physicians today have practices that manage between 3,000 and 5,000 patients annually. That means as good and qualified as your current doctor may be, he or she can likely only spend about five minutes with you per visit. You can do better, and so can we.” But this increased personal attention comes at a price—in the case of OneMD, which has now been in business for ten years, the annual fee is currently $4,500 per patient, or $7,000 for a couple.[lxxiii]

Not every concierge practice sets its fees at this level. For example, Keith Michl, an internist in solo practice in Manchester, Vermont, limits his panel of patients to 600 and charges an annual fee of $1,500, while, as noted above, family physician John Haresch, who has 650 patients in his North Carolina solo practice and spends 45 minutes on each follow-up visit, charges an annual fee of only $75 (although he doesn't describe his practice as a concierge model).

Dr. Michl started his medical career in 1984 in a three-physician group that, like so many

small groups, began having financial and organizational problems until eventually he and his partners sold the practice and became hospital employees. “It worked nicely for the first five years,” Dr. Michl recalled in an interview with *Repertoire*, “but as my tenure ended, I found myself increasingly frustrated... I felt I wasn't in charge of my destiny.” [lxxiv] And so, following what he described as an amicable break-up with the hospital, Dr Michl opened a rural solo practice where he hoped to have a more control over his practice. But soon he found that he had little time for his patients, cramming in some 20 to 30 appointments a day, working very long hours, and struggling to stay alive financially. Once again, Dr. Michl began searching for alternatives.[lxxv]

A colleague who had gone the same route from hospital employee to solo practice told him about a Florida-based company called MDVIP that had helped him convert his practice into a more sustainable, wellness-oriented concierge model. And so Dr. Michl got in touch with MDVIP to see whether there might be a fit. MDVIP came in and conducted a very thorough analysis of his practice, including interviews with several hundred of his patients, and in September 2011, Dr. Michl announced that he would be joining MDVIP.[lxxvi] This meant that, for the $1,500 annual fee, his patients would receive a comprehensive wellness program, including a thorough annual physical; 24/7 access to Dr. Michl by his cell phone and e-mail; same-day appointments; and much longer visits than had been possible when Dr. Michl had had to “cram in” 20 to 30 patients a day in order to make ends meet. For Dr. Michl, it meant signing an affiliation agreement with MDVIP under which a third of the $1,500 patient fee would go to MDVIP for their assistance in setting up and managing the practice, as well as for coverage of some of the prevention and wellness services not covered under ordinary insurance. He also agreed to limit his total number of patients to no more than 600—and this of course meant that some 1,400 of the 2,000 patients in his former practice would now have to go elsewhere for their care. According to Dr. Michl, for those patients who couldn't or wouldn't sign up with his new practice, he was able to identify other physicians who could squeeze more patients into their practices, including a new generalist physician who still had a lot of openings. When we asked Dr. Michl whether he had any regrets about limiting his practice, he acknowledged that he did, but felt that he didn't have any choice given that he's working in a “broken” health care system.

He had concluded that if he wanted to continue practicing high quality medicine and survive financially, he had to do something.

Dr. Michl's concierge-style practice is not an isolated case. MDVIP, which was started 11 years ago in Boca Raton, Florida, and was purchased by Proctor and Gamble in 2010,[lxxvii] currently has more than 500 physicians in its network serving some 80,000 patients in 39 states and just about every major metropolitan area, according to company officials we spoke with. And there are other companies also entering the concierge practice market, such as MD Squared, a Seattle-based company that charges an annual fee of $15,000 and limits its participating physicians to no more than 50 patients.

But not everyone is a fan of the concierge model. Blogger Scott Isaacs, for example, complained that "this goes against what doctors are supposed to do, which is to help people. The most helpless, those with the least money, get left by the wayside." His post received 197 comments, most of them in strong agreement.[lxxviii] And of course there are physicians like North Carolina's Dr. Brady, who considered the concierge option but decided that he didn't want to charge his patients any more than they were already paying for their health insurance.

Active practice management

Not every physician who wants to remain in private practice is necessarily joining a large group or an IPA, or setting up a micropractice or a concierge practice. Some are simply riding out the storm in the hopes that they can keep their practice afloat until they retire in a few more years, while others, who are in it for the longer haul or who want to see their practices continue beyond their retirement, are shoring up their practices through a variety of steps to cut costs and/or enhance revenues—in other words, through more active practice management.

Dr. Debra Miller, age 56, who owns a pediatric practice with some 2,000 patients that she

operates with a part-time 62-year-old fellow physician in Ottumwa, Iowa, is essentially riding it out. She's had to update her practice management software and hardware because the original vendor is no longer in business, but says she doesn't plan to buy an electronic medical record system because of the cost. “It takes ten years to recoup the cost,” she told us, “and I don't plan to be in practice that long.” Her practice revenues have been stable, she says, because although she's been seeing more Medicaid and Hawk-I patients (Hawk-I is Iowa's version of the Children's Health Insurance Program and covers children in low-income families who don’t qualify for Medicaid), she is also seeing fewer uninsured patients, largely because those children are now covered by Medicaid or Hawk-I. Like just about everyone else we spoke with, she said that dealing with the insurance companies has become more of a headache—for example, by limiting the hospitals to which she can refer her patients—but added that “my staff handle most of that,” and said that so far she hasn't needed to hire any additional administrative staff to deal with the increased burden. Overall, she rates her satisfaction with her practice at an 8 on a ten-point scale, and says that it would be a 10 if it weren't for the insurance hassles and occasional employee management issues.

Similarly, Dr. Neil Cohen, age 62, and his partner Dr. Samuel Lizerbram, age 68, are keeping their two-man family practice in Philadelphia, Pennsylvania, going without making any major changes. “We're not taking Medical Assistance patients any more, and we're taking fewer managed care patients,” but mostly, Dr. Cohen said, their patient base has been stable. “We're ignoring EMR for now,” he told us, “since the penalties don't kick in until 2015 and the cost of converting all our existing files would be high.” And although, as we noted earlier, their practice costs have been outpacing revenues in recent years, Dr. Cohen and Dr. Lizerbram have absorbed the losses themselves rather than reducing their employee costs, because employee retention is a high priority. Dr. Cohen said that while some doctors he knows have been “getting into additional services”—for example, opening a Suboxone clinic for patients with opiate addictions—he and his partner aren't doing anything like that. He is reluctant to join a larger group, he said, in part because “it would mean giving up some of the perks that come with owning your own practice.” And despite some of the challenges, Dr. Cohen rates his satisfaction with his practice at a 10 on

a ten-point scale. “I love seeing my patients,” he explained.

While Dr. Miller and Dr. Cohen are not contemplating any major changes in the remaining years of their practice, Dr. Doug Curran and his colleagues in an eleven-physician family medicine practice in Athens, Texas, have taken a more proactive approach to ensure that their practice survives, and even thrives, in the years to come. While Dr. Curran and two of his partners are in their sixties, the group also includes three physicians in their thirties and two in their forties, which gives the group a different planning horizon than an older practice might have. As noted earlier, the group members made a major investment in a medical record system several years ago, including the addition of “scribes” to their staff to enter the necessary information into the system during patient visits.

With regard to practice finances, Dr. Curran said, “We're in a good position,” but stressed that “you have to stay on top of your cash flow.” Toward this end, all eleven partners meet every Thursday morning to review the most current financial reports. “You have to watch your intermediaries,” Dr. Curran cautioned. “You also have to watch your patient mix to make sure that you're not seeing too much Medicare, Medicaid or no pay.” This will become even more of an issue, he said, once the insurance expansion provisions of national health reform are implemented in 2014. To enhance revenues, the practice added a mammography service ten years ago and is now adding lab services. In addition, Dr. Curran emphasized the importance of working as a team that includes non-physician providers such as physician assistants, nurse practitioners, nutritionists and psychologists.

While he worries about how to recruit young physicians to the group as he and his senior colleagues prepare to retire, and about how to keep the state and federal governments from intruding any further into the doctor-patient relationship, Dr. Curran is enjoying his practice and rates his satisfaction at an 8 on a ten-point scale. “My patients are my friends,” he told us proudly. “They all know my receptionist's name. They say, 'I'll call Christine.'”

Like Dr. Curran, Dr. Steven Stine belongs to an eleven-member independent practice—in his case a radiology group in Wasau, Wisconsin, that works with one hospital system. “We

run a three-year contract with the hospital," he told us, "and in the negotiations they ask us, 'Do you want to be an employee?' We tell them no. Would it make a difference if we were hospital employees? I believe so. We would lose a lot of leverage." And in fact, another member of the group told us that he had previously left a radiology group elsewhere in the state when it was absorbed by a large health system and its members became employees. Fearing that the health system would begin chipping away at some of the supports that had made it possible for him to practice high-quality medicine, he says that that is precisely what happened, and that after the initial contract with the practice was up, the health system tried to negotiate a salary reduction with the radiologists—who had lost their bargaining leverage since they were now employees.

But remaining independent requires a real effort on the part of the physicians themselves, Dr. Stine warned. "Doctors generally don't do a good job of business—payments, marketing, PR, admin, EMR systems and the like. But they have to become involved, to understand the business end." That includes understanding the hospital's interests and concerns, he added, so that you can find the "sweet spot" where your interests and the hospital's overlap. Toward this end, Dr. Stine emphasized the importance of having a physician in the practice who understands either business or law—"who can understand and speak the lingo." In addition, Dr. Stine said, it is essential to stay current—for example, the group uses the new PACS digital radiology image transfer system—and to keep on top of the practice's operating costs. "We have built a solid independent practice because we control costs and do not overutilize medical resources."

The flipside of cost control is revenue maximization, and this has been a top priority for Dr. Jeff Hyman, medical director for the 65-physician University Physicians Group, which was founded 21 years ago and now has 28 locations in Staten Island and Brooklyn, New York. His mantra, he told us, is "No dollar left behind." And to ensure that the practice does in fact collect every dollar it is owed, he: (1) has outsourced collection to a third-party billing and collections firm; (2) collects all deductibles and co-payments at the time of service; and (3) has implemented an electronic medical record system to ensure appropriate coding. As a result, Dr. Hyman says, the group has maintained its independence and

"continues to thrive."

As it was for Dr. Curran's group in Texas, the electronic medical record system was initially disruptive. But now it is viewed as an asset, not only for coding purposes but also because it enables the group's physicians to report on HEDIS (Healthcare Effectiveness Data and Information Set), PQRI (Physician Quality Reporting Initiative) and "Meaningful Use" measures that can bring in additional revenues. And in contrast to some of the other physicians we spoke with, Dr. Hyman did not find this kind of quality of care reporting onerous. Calling it "upliftingly correct," he maintained that there is nothing wrong with keeping track of key clinical indicators such as A1c levels, blood pressure, and lipid levels. Along the same lines, Dr. Hyman said, the practice is also retraining its physicians to practice appropriate care and not to overuse tests and diagnostic procedures—or, as he put it, "not to order an MRI for every patient who walks in with a headache."

Finally, although the number of solo practitioners has undoubtedly continued to fall since the AMA reported that roughly one in four physicians was in solo practice in 2007-2008, they are not yet by any means extinct. After all, one in four means that there were close to 200,000 physicians in solo practice just four years ago, and presumably many of them are still active today. One such physician who has managed to hold his own in solo practice for more than 30 years now—and who told us that he rates his satisfaction with his practice at an 11 on a ten-point scale—is Dr. Sanford Brown, a family physician in Fort Bragg, a small town on the northern California coast. The secret to the continuing success of his practice, Dr. Brown said, is that he keeps his overhead costs low. In contrast to the pure micropractice model, he has one administrative employee so that he can devote all of his time to taking care of his patients, but he is fully cross-trained so that in the event that his administrative employee is out of the office, he can take care of all of her responsibilities as well as his own—and he says he did so "without a hitch" once when she was out on maternity leave for four months. "You have to know the nuts and bolts of your practice so you know what to do if your administrative person is out," he says, a fact that he "learned the hard way" when one of his previous assistants was out for a while and his practice was stopped in its tracks. "But it really isn't that hard," he observed. "And it's a small price to

pay for maintaining your independence."

Although he does not have an electronic medical record system, in a recent column Dr. Brown talked about the importance of a computer in running his solo practice ("Running an office without a computer is like using leeches for phlebotomies"), but he cautioned that "having a computer isn't enough. You have to know how to use it to make appointments, create bills, post payments, and send electronic claims… This is your business, and for it to be successful, you need to be involved with its nuts and bolts. An aloof attitude (eg, 'I just want to practice medicine') will leave others running your business for you, often with calamitous results." He also emphasized the importance of giving patients "great service," which he said means that it is important to "keep your hands off the doorknob while you're with patients." [lxxix]

Dr. Brown sees about 15 patients a day, and says he is doing well financially. He believes that his model of solo practice is eminently viable, even in today's tough reimbursement environment, but he says that as far as he knows, he is the only solo practitioner in his area. He believes that many of his fellow physicians are reluctant to become involved with the administrative and business aspects of medical practice ("They don't teach any of that in medical school") and consequently they are joining hospitals and health systems where those issues are "taken care of for them." As for the added leverage that a hospital or health system might have in negotiating higher reimbursement rates with insurance companies, Dr. Brown believes that much of that higher rate does not filter down to the physician, at least not in the long run. "When you stop and think about it, the doctors are actually carrying all those administrative people at the hospital," he reflected, "while I just have one administrative person and I keep my other operating costs to a minimum."

Summary and Recommendations

After learning that his obituary had been published in the *New York Journal*, Mark Twain is famously said to have remarked that the reports of his death had been greatly exaggerated. The same could be said today for private medical practice in this country. Even if the dire Accenture projection comes true and only one in three American physicians remains truly independent in 2013, this will still represent more than a quarter of a million physicians in private practice—not an inconsequential number.

Nevertheless, while there have been no nationally representative physician surveys that have looked at practice ownership since 2008, it seems apparent from multiple sources—including physician recruitment data, site visit reports from nationally representative metropolitan areas, and the insider perspectives of a wide range of health care experts—that the pace of decline in independent practice that we reported in our 2008 study has picked up dramatically over the past four years, to the point that in some areas, private practice—especially among solo and small group practices—is practically in freefall. To put the recent trends in perspective, in our previous report we found that private practice had been declining at an average annual rate of about 2 percent from 1983 to 2008. But if the Accenture projection is borne out and we go from the AMA's finding of about 60 percent of physicians in private practice in 2008 to only about 33 percent in 2013, this will represent almost a 50 percent decline in just five years.

While the enactment of national health reform in 2010 may account for some of the recent plunge in private practice, it is by no means the whole story. Operating costs for staff, benefits, space, equipment, technology, malpractice coverage, and regulatory compliance have simply been rising faster than revenues for many private practices, putting them in an increasingly unsustainable position—especially smaller practices that lack the leverage to negotiate more favorable reimbursement rates. Meanwhile, in many communities, hospitals and other large health systems eager to further expand their negotiating leverage with insurers are making attractive offers of employment to the increasingly desperate physicians still in private practice, and many of those physicians are responding.

Many, but not all. Some physicians who have only a few more years to go until retirement are simply battening down the hatches and riding out their remaining years without making any major changes to their practice. But others who are in it for the longer haul—including some physicians who have given employment a try and found it wanting—are taking more active measures to preserve and protect their independence, such as joining independent practice associations, merging with other independent practices, establishing micropractices, venturing into concierge medicine, or simply becoming more aggressive about cutting costs and enhancing revenues within their existing practices. And in fact, not only are many of these physicians surviving, some are thriving. What's more, many of those we spoke with rated their satisfaction with their practice at the high end of our ten-point scale, despite the growing "hassle factor" of dealing with restrictive insurance company policies and intrusive regulatory requirements.

So what broad conclusions can be drawn from these developments with regard to the future of private medical practice in this country? We would emphasize the following:

1. The health care environment is going through a period of fundamental change, driven by both formal and informal reform, and those private practices that are unable or unwilling to change accordingly are unlikely to survive over the long haul. In other words, business as usual is not an option.
2. For those who are willing to change and adapt to the new health care realities, it is possible not only to survive as an independent private practice physician but to thrive—and to achieve a high level of personal satisfaction in the bargain. But it will take real work to make it happen, and may require getting outside of one's comfort zone, for example by becoming more directly involved in the business aspects of the practice. As Dr. Don Bradley, a family physician and chief medical officer for North Carolina Blue Cross-Blue Shield, put it, "Independence is a good thing, but how you remain independent will require a new paradigm…You can't be Marcus Welby any more."
3. There are multiple options for those who want to maintain their independence, depending on one's personal preferences and, to some extent, local market

conditions. Some physicians, for example, are not comfortable practicing in a group setting, while others are not comfortable with the ethics of concierge practice. As for local market conditions, L. Gordon Moore cautions that although the micropractice model works well in many areas, there are certain "dead zones" where conditions are simply not right to support a micropractice. Similar limitations may apply to other models as well.

4. There are steps that payers and policy makers can take that can help to sustain private practices so that they are not forced into the arms of large hospital or health systems. For example, Dr. John Haresch told us that his micropractice on the Outer Banks got a substantial boost when North Carolina Blue Cross-Blue Shield increased payments to primary care physicians by almost 20 percent. Conversely, had the Medicare cuts for office-based cardiology diagnostic procedures been less draconian, it is likely that many more cardiologists would have remained in private practice.

This last point seems obvious enough, given that much of the pressure that is driving physicians out of private practice is economic. What may be less obvious is that it could well be in the economic *interest* of payers to pay a little extra—as North Carolina Blue Cross-Blue Shield did—in order to help preserve private practices. The reason is that enabling physicians to remain in private practice could help to slow some of the hospital-system consolidation that has been a key factor in driving up costs for payers in many markets around the country. In testimony last September before the House Ways and Means Subcommittee on Health in its hearing on health care consolidation, Paul Ginsburg, president of the Center for Studying Health System Change, cited data from the American Hospital Association which indicated that "the ratio of private payer rates to hospital costs increased from 116 percent in 2000 to 134 percent in 2009"—meaning that hospitals' effective profit margin had more than doubled in less than ten years. Ginsburg went on to state that "provider consolidation is clearly a factor behind provider leverage," adding that "to date, hospitals' primary motivation for employing physicians has been to gain market share, typically through lucrative service-line strategies." [lxxx] Along the same lines, the *New York Times*, in a 2010 story titled "More Doctors Giving Up Practices," observed that

"for all the vaunted efficiencies of health care organizations, there are signs that the trend toward them is actually a big factor in the rising cost of health insurance. In much of the country, health systems are known by another name: monopolies."[lxxxi]

Of course, this hospital-system consolidation has in part occurred in response to increasing consolidation on payer side. But for our purposes, the recent surge in provider consolidation may present a window of opportunity to make the case to payers that it is in their economic self-interest to assist private practices—especially the smaller ones—rather than taking the more short-sighted path of, in effect, forcing them out of business because they don't have the leverage to negotiate a "livable" reimbursement rate. Dr. Kevin Schulman, a professor of medicine and business at Duke University who has written extensively on consolidation in the health care field, told us that "some insurance companies are waking up to this," and declared, "If I were an insurance company, I'd be doing everything I could to prop up these private practices." We should add that employers and other large entities that are actually paying the premiums clearly have a stake in this as well, perhaps even more so than the insurance companies themselves.

Beyond the four broad conclusions listed above regarding the future of private practice, we also learned in the course of our research that the most current hard data on practice ownership in this country—which come from the AMA and Center for Studying Health System Change surveys conducted in 2007-2008—are now four years old. While four-year-old data might have some utility in a period of relative stability, all available indicators suggest that the past four years have been anything but stable. In the absence of more current national data, it is difficult to fully understand and raise awareness about the profound changes that appear to be taking place on the front lines of the nation's health care delivery system. We also were not able to identify any information regarding the public's awareness about what is happening to private medical practice, or the public's views regarding these trends. Such information could be of great importance to policy makers, as well as to the medical profession itself. Finally, in preparing our previous report on independent practice, we found little evidence regarding the impact of practice ownership on patient care or patient satisfaction, and the scant evidence that did exist was

largely mixed. Four years later, we have not been able to find any new research findings on this key question.

Recommendations

Based on our review of the most recent trends in private practice, the forces behind those trends, and the various ways in which private practices have sought to respond to those trends, we offer the following recommendations:

1. Medical societies, specialty societies, medical schools, and other credible organizations with access to physicians should take immediate steps to alert the nation's private physicians, employed physicians and physicians about to enter practice that, despite the recent surge in hospital and health system employment, there is a range of viable models of private practice available to them that would enable them to retain their financial and professional autonomy and derive a high level of personal satisfaction. This outreach effort should make use of all available channels of communication, including print and online newsletters, professional journals, webcasts, etc., and should include construction of a high-quality website by the Physicians Foundation or some other organization without a financial stake in any particular model or approach to provide physicians with readily accessible information about each of the alternative models and strategies, and links to resources where they can obtain additional information. The basic message of this outreach effort should be that, for those physicians who would prefer alternatives to employment, there is a menu of viable real-world options out there for them to consider.
2. Funding should be made available to cultivate and test promising new models of private practice that may emerge as the health care environment continues to evolve and new practice-related technologies come on stream. Priority should be given to those models that appear to be financially viable in the new environment and that enable physicians to: (1) remain independent, (2) provide high quality care to their

patients, and (3) preserve the doctor-patient relationship. Successful models should be promoted through the same channels described above.

3. Health care payers, including employers, government and insurance companies, should be encouraged to increase payments and provide other forms of support (such as subsidies for implementation of electronic medical records) that will enable physicians in private practice to remain independent, on the grounds that relatively modest support to these physicians is a far less costly alternative to the hospital-system consolidation that will occur if these physicians are driven into the arms of a large hospital or health system.
4. A new national physician survey should be fielded as soon as possible to provide definitive data on the current status of private practice, as well as recent trends. In order to obtain reliable trend information, the new survey should be constructed and conducted in such a way that its findings can be directly compared with findings from the most recent AMA and/or Center for Studying Health System Change surveys. The findings from the survey should be widely publicized and shared with policy makers and the public, as well as with the medical profession itself.
5. Research should be undertaken to determine the public's level of understanding and concern about the current decline in private practice. This should include focus group as well as survey research, and should be conducted by a reputable, high-profile national public opinion firm to ensure the quality of the research and the credibility of the results with the press, the public and policy makers. If the findings indicate a low level of awareness but a high level of concern among those who *are* aware of what is happening, efforts should be undertaken to inform the broader public of what is happening through a coordinated campaign of press releases, op eds, interviews with the press, etc.

A Concluding Observation

In pulling together the information for this report and talking with a broad cross-section of industry insiders and health care experts, we encountered a strong current of pessimism regarding the future of private practice—a pessimism which, we should add, was reflected in the title of our own 2009 paper in the *New England Journal of Medicine* based on our previous report to the Physicians Foundation: "The Independent Physician: Going, Going…" [lxxxii] And indeed, such information as we were able to piece together about what has been happening since we wrote that paper—especially in many local health care markets—seemed to directly confirm that pessimistic outlook.

Yet as we started to learn more about some of those private practices that have somehow managed to buck the trend, and as we talked to the physicians who are running those practices, we began to wonder whether maybe, just maybe, this isn't the end of private practice after all. What it clearly *does* seem to be is the end of the traditional model of private practice, a model that, as a result of the steadily mounting financial and other pressures described in this report, has in too many cases forced physicians into a kind of mad hamster wheel that just keeps spinning faster and faster—or as Dr. Mark Wheeler's patient so aptly put it, "A three hour wait for a 20 second ride."

But the same pressures that are driving many traditional private practices to sign on with their local hospital or health system also appear to be sparking pockets of experimentation and innovation that are producing striking new models and strategies that are much more in tune with today's brave new health care world—like the models and strategies that we have described in this report. Moreover, there is every likelihood that as conditions continue to evolve and as new technologies present additional opportunities for innovation, still more new models and strategies will emerge that will enable those physicians who truly value their independence to remain in private practice. And as David Gans of MGMA and others have pointed out, the ability of small independent practices to "turn on a dime"

and to "adapt to changes in insurance or whatever comes down the road" may well give

them a competitive advantage in periods of rapid change such as we are currently experiencing.

The key for those wishing to preserve private practice as an option—both for physicians and for patients—will be to get the word out to as many physicians as possible that there are indeed real options out there that can be replicated and adapted to meet their needs, so that these models of private practice can spread and take root in many more communities across the country. At the same time, a concerted effort should be made to convince policy makers and payers that it is in their best interest to support private practice rather than treating it as collateral damage in the reconfiguration of the health care system. We believe that if these steps are taken, private practice will remain an integral part of the nation's delivery system well into the future.

Appendix: People Interviewed for this Report

1. Rick Abrams, (former) executive vice president, Medical Society of the State of New York**
2. Philip Bale, MD, family practitioner, Glasgow, Kentucky
3. Robert Blendon, ScD, Harvard University School of Public Health, Boston, Massachusetts
4. Don Bradley, MD, MHS-CL, senior vice president for healthcare and chief medical officer, North Carolina Blue Cross-Blue Shield, Durham, North Carolina
5. Lawrence Braud, MD, otolaryngologist, Baton Rouge, Louisiana*
6. Sanford Brown, MD, family physician, Fort Bragg, California
7. Neil Cohen, DO, family physician, Philadelphia, Pennsylvania
8. Andrew Costin, MD, cardiologist, Princeton, New Jersey
9. Douglas Curran, MD, family physician, Athens, Texas
10. Steven Ellison, MD, general internist, Ottumwa, Iowa
11. Paul Ginsburg, PhD, president, Center for Studying Health System Change, Washington, DC
12. Louis Goodman, PhD, executive vice president and CEO, Texas Medical Association Austin, Texas*
13. Chip Harbaugh, MD, pediatrician, Atlanta, Georgia
14. John Haresch, MD, family physician, Kill Devil Hills, North Carolina
15. Lynn Ho, MD, family physician, North Kingston, Rhode Island
16. Jeffrey Hyman, MD, general internist and medical director, University Practice Associates, New York, New York
17. David Isaacs, MD, radiologist, Wasau, Wisconsin
18. Palmer Jones, executive director, New Hampshire Medical Society (retired), Concord, New Hampshire*
19. J. Kim, MD, radiologist, Cumberland, Maryland
20. Andrea Klemens, MD, medical director, MDVIP, Boca Raton, Florida
21. Joel Klompus, MD, internist and CEO, Brown and Toland, San Francisco, California

22. Jack Lewin, MD, CEO, American College of Cardiology
23. Larry Lindeman, MD, family physician, Chicago, Illinois
24. William Mahon, CEO, South Carolina Medical Association (retired), Charleston, South Carolina*
25. Seth Matarasso, MD, dermatologist, San Francisco, California
26. Keith Michl, MD, general internist, Manchester, Vermont
27. Debra Miller, MD, pediatrician, Ottumwa, Iowa
28. L. Gordon Moore, MD, family physician, Seattle, Washington
29. Donald Nowinski, MD, radiologist, Wasau, Wisconsin
30. Walker Ray, MD, pediatrician (retired), Atlanta, Georgia*
31. James Reschovsky, PhD, senior fellow, Center for Studying Health System Change, Washington, DC
32. Richard Reynolds, MD, general internist (retired), West Milton, Ohio
33. Steven Schroeder, MD, general internist and professor, UCSF, San Francisco, California
34. Kevin Schulman, MD, MBA, professor of medicine and business, Duke University, Durham, North Carolina
35. Aubrey Schwartz, MD, orthopedist, Oakland, California
36. David Sherman, MD, cardiologist, New York, New York
37. Steven Shortell, PhD, dean, UC Berkely School of Public Health
38. Steven Sloan, MD, otolaryngologist, San Francisco, California
39. Steven Stine, MD, radiologist, Wasau, Wisconsin
40. Mitchell Seltzer, health care consultant, Princeton, New Jersey
41. Claudia Tellez, executive director, Medical Society of Northern Virginia, McLean, Virginia*
42. Nancy Udell, director of media relations, MDVIP, Boca Raton, Florida
43. Lawrence Wolper, MBA, medical practice consultant, New York, New York
44. Michael Ziegler, JD, health care partner, Duane Morris, New York, New York

* Board member, Physicians Foundation

** Former board member, Physicians Foundation

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