

In a complex environment, physicians have at least 8 paths to choose from

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Physicians are caught between pressures on practice revenue and rising costs. Regulatory restrictions have in some cases also limited options for revenue diversification such as joint ownership of imaging centers and ambulatory surgery centers.

Add to this mix the ever-increasing burden of government- and insurance-related administrative tasks, and it doesn't take 20–20 vision to see that the idea of operating a Marcus Welby-type practice is nothing but a “mythical vestige of the past,” according to David W. Hilgers, an Austin, Texas-based attorney with 40 years' experience negotiating provider contracts and advising clients on state and federal regulation of fee-sharing, self-referral, antitrust, licensing and privacy issues.

While physicians may believe they have no clear path forward, Hilgers believes most doctors have at least eight distinct options. The uncertainty lies in which of these to choose.

At the same time, two facts are also becoming clear: Economic and regulatory forces favor integrated practices, and physician shortages combined with an aging population should put many doctors in advantageous positions with increased bargaining power—especially with accountable care organizations (ACOs) that need to build primary care capacity.

The AMA has developed a resource that is part of a new webpage on payment essentials that offers a nuts-and-bolts approach physicians can use for evaluating proposals, negotiating agreements and managing revenue cycles under new payment models.

Although some small physician practices may face challenges as payment and delivery systems evolve, it is also true that solo physicians in large cities may find advantages operating as a concierge or direct primary care practice, or small practices in small towns may have the clout needed to form a strong partnership with a local hospital. “The hospital may threaten to bring in a competing doctor, but that may not be a real threat given the shortage of physicians,” Hilgers writes.

Physicians and medical groups need to conduct a serious self-assessment to set realistic goals and determine their capacity to reach them. This will guide their decision on which of the eight options below they should choose.

Don’t do anything. There may be a psychological pressure to do “something” in the midst of frenzied buying and merging, but standing pat could be a viable option for some physicians in unique situations. Hilgers lists in vitro fertilization specialists or clinicians in a larger specialty group that haven’t seen substantial revenue decreases as examples of physicians who may find it advantageous to watch and wait.

Stand pat, but attempt to grow the practice. “One fact that seems to be clear even in the muddled situation that we face is that larger will often be better,” Hilgers writes. But smaller groups that are not facing immediate financial pressure may be able to continue their present course while adding physicians or merging groups. “This larger size will allow the group to be more flexible as it adapts to whatever may come in the future,” according to Hilgers.

Employment by hospitals. This may be a way for many to eliminate substantial administrative responsibilities while gaining the infrastructure that allows physicians to compete.

Form large clinically integrated practice associations that can negotiate as one. This option allows individual physician groups to remain largely independent while negotiating as a part of a larger group for payment and clinical control.

Change to a concierge or direct practice. As long as this type of practice methodology is legal, it certainly may remain a viable option.

Partner with hospitals. Physician groups may be able to develop service-line management companies allowing them to retain independence while receiving compensation from hospitals, ACOs or integrated delivery systems.

Partner with health insurers. Partnering with payers can be a way for physicians to obtain the capital and data necessary to operate an ACO. It may allow physicians to reduce hospitalizations without the potential pushback of a hospital partner. But the success of such a venture will depend on an insurer's willingness to cede significant control to physicians.

Sell or merge with venture-based consolidations. Bankers are making significant investments aimed at creating national medical groups that can negotiate with payers to build value-based organizations. So far, this has been effective with hospital-based specialties like anesthesiology and pathology, but there has been activity with other specialties as well.

In order to make the best decision for their own unique situation, physicians and medical groups need to assess the cohesiveness of their practice as well as their financial situation, ability to invest in technology and infrastructure, bargaining position in their community, and years left in practice.

Hilgers suggests that physician groups consider hiring a consultant who can help them evaluate these options. Also, there should be an understanding that money gained by selling may be offset by reductions in future compensation and "there needs to be some benefit to your group other than the one-time payment."