Rising costs, flat revenue and concerns about patients moving to high-deductible insurance products could make 2006 a difficult year for medical groups, says Mark Shields, M.D., senior medical director with Advocate Health Partners.

“The future looks tough. The expense side is going up faster than the revenue side,” Shields says. “Doctors will face higher debt and more upfront collections with the high-deductible, consumer-driven health plans. I don’t think this is an issue that has sunk in operationally to most physician practices.”

On the other hand, Shields says the growing use of electronic medical records, pay-for-performance and renewed partnerships with hospitals could temper negative trends.

While physicians were scheduled to absorb 4.4% in Medicare reimbursement cuts set to take effect Jan. 1, Congress was working to freeze the rate at deadline. A final vote on the deficit reduction measure—aimed to

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lower the $314 billion federal budget deficit projected for 2006 by the Congressional Budget Office—is expected in January.

“The best-case scenario is that Medicare will go up 1%. The worst case is 4.4% down,” says Shields, whose Oak Brook, Ill.-based physician-hospital organization has 2,700 members. “Managed-care organizations also are doing their best to reduce compensation. We hope to demonstrate improved outcomes, higher quality and safety to payers and use that to negotiate higher rates.”

Seeing payment cuts coming, most medical groups have budgeted for reductions, says William Jesse, M.D., president and chief executive officer of the Medical Group Management Association. The MGMA represents about 237,000 physicians, with about 69% of members in small medical groups with 10 or fewer physicians.

“It will be a pretty significant blow to most practices, especially with expenses going up 5.5% per year,” Jesse says. “The outlook for groups is the worst in many years, particularly for primary-care practices. Specialists have the ability to do ancillary services like imaging services to create new revenue streams.”

In a 2005 report to Congress, Medicare’s trustees estimated cuts from the Balanced Budget Act of 1997 would reduce reimbursements 25% from 2006 to 2011. During that same period, physician expenses are expected to rise 15%.

“The financial vitality of groups is worse than” in past years, says Don Fisher, president and CEO at the American Medical Group Association. The AMGA represents large multispecialty groups with an average size of 272 physicians.

Ironically, Fisher says the reimbursement cuts are coming at a time when government and private payers are asking doctors to invest in EMRs. “Groups are not going to run out and spend $400,000 on an EMR system if their reimbursements are cut,” Jesse says.

One way medical groups can address declining reimbursement is to focus on production through innovation, says Roger Schenke, executive vice president of the American College of Physician Executives. Typically, doctors increase production by working more hours, seeing more patients or performing more health services. But Schenke says using information technology also can increase production. “The problem is there needs to be more systems to pay physicians for answering e-mails from patients,” he says.

Steve Shortell, dean of the School of Public Health at the University of California at Berkeley, says medical groups that install EMRs will fare better in 2006. “Medical groups have more incentives to adopt EMRs and care-management processes,” he says. Care-management processes include the use of hospitalists, case management and clinical guidelines.

Another challenge for groups is capitalizing on pay-for-performance opportunities in which physicians are paid financial bonuses for hitting various clinical, quality and patient satisfaction targets. “Pay-for-performance is gearing up faster than anyone thought,” Fisher says.

Large medical groups “will come out better than solo doctors and small groups because many have already invested in medical technology and can do (data) reporting.” Physicians also are expected to expand the types of products sold in their offices, says Hank Duffy, president of the JHD Group, a consultancy. “They need to find alternate ways to get revenue,” he says. “It is everything from selling vitamins in their office to offering more ancillary services like bone density and stress tests.”

Lisa Goldstein, senior vice president with ratings agency Moody’s Investors Service, says physicians and hospitals will partner in a variety of ways reminiscent of the 1990s, but with more strings attached. “As payers rapidly consolidate, hospitals and doctors are coming together to be that indispensable network for contracting,” Goldstein says.

During the 1990s, hospitals aggressively acquired medical groups and employed physicians in an effort to build integrated delivery systems.

“In the past, hospitals that employed physicians didn’t set clear productivity goals and that led to financial disaster,” Duffy says. “We are encouraging hospitals, if it makes sense, to buy or build an owned physician practice. But you have to have a compensation system that is productivity- and incentive-oriented.”

Goldstein says doctors are more amenable to hospital employment now “because they are seeing their income restrained and want more economic security. They seek access to capital for information technology and help in paying their malpractice premiums. Hospitals want more market share and those star physicians.”

Joint ventures also will flourish in 2006 between hospitals and doctors, Duffy says. “The war between doctors and hospitals over surgery centers, endoscopy centers, imaging centers may
start to subside,” he says. “The (specialty hospital) moratorium put a spotlight on the fact that it is not a good thing for hospitals and doctors to become competitors.”

To finance joint ventures, some hospitals have issued private placement bonds that are purchased by doctors. “The goal of the hospital is to tie the doctor financially to the hospital doing well,” Goldstein says.

In return, physicians sign noncompete clauses that prevent physicians from using other facilities or starting their own services within a certain radius of the hospital over an agreed upon period of time, Goldstein says.

Most experts also predict more groups and independent practice associations will merge, affiliate and integrate clinical and administrative operations.

“IPAs understand they must be more integrated to negotiate managed-care contracts,” Duffy says. “The FTC made it very clear with the Brown & Toland agreement that groups need to (integrate) to avoid antitrust scrutiny.”

In 2004, Brown & Toland Medical Group, San Francisco, settled an FTC antitrust complaint that alleged the 1,500-physician IPA improperly fixed prices of PPO contracts for member doctors without undergoing sufficient clinical or financial integration. About 15 other “messenger-model” IPAs nationwide have struck similar settlements. The FTC suggests integration can be done in several ways, including implementing an active program to evaluate and modify network physicians’ practice patterns and by creating a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

Jessee says he expects smaller practices to consolidate to take advantage of economies of scale and for managed-care contracting. But small practices still dominate the landscape. In a 2003 survey, the American Medical Association found 43% of some 20,000 group practices have three to four physicians. There were only 241 groups with 100 physicians or more, the AMA says.

Donald Crane, president and CEO of the California Association of Physician Groups, says medical groups that accept capitated reimbursement are struggling somewhat with their identity because insurers are moving to PPOs and high-deductible products.

“To the extent capitation declines and reimbursement moves to fee schedules, this provides groups with just enough money to survive,” Crane says. “There is no money to develop systems of care and information technology.”

Jessee: Expect consolidation for small groups.