

Big Ideas

The Case for Independent Physicians

Changes to the healthcare industry have caused many to conclude that there is no viable role for independent physician practices in the future.

We beg to differ.

This paper looks at the healthcare situation broadly – as it was, as it is, and as it is projected to be – and then makes a fact-based case for why we are bullish about a positive future for independent physician practices. It is a contrarian view, but one we believe to be ripe with opportunity.

EVENTUALLY, GRAVITY WINS: THE CASE FOR INDEPENDENT PHYSICIANS

EXECUTIVE SUMMARY

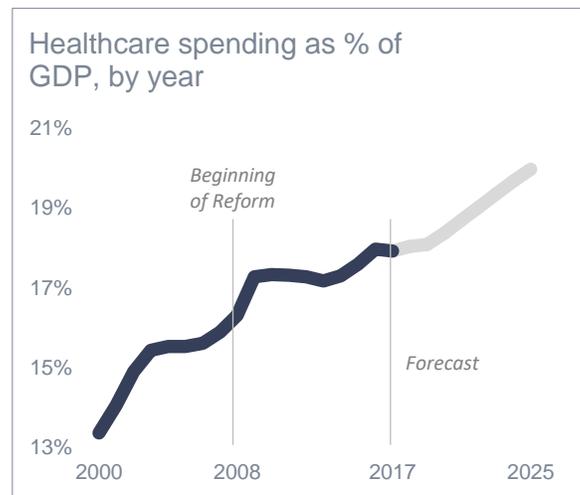
A decade ago, the country collectively decided healthcare costs had reached a crisis. A reform agenda, both policy and market changes, based on these four key ideas was launched in earnest:

- Increase the number of people with health insurance.
- Pay healthcare providers for value and outcomes instead of volume.
- Provide care through integrated delivery systems financially at risk for quality and cost.
- Leverage information technology to make the entire system and industry more efficient.

These ideas strongly favor massive organizations leading many to believe there is no future for the independent physician practice. In fact, 44% of physicians are now employed by hospitals and health systems, a rate almost double that of a decade ago.

However, as the data continue to pour in it is increasingly obvious that no matter how well intentioned the reformers are, the approach is built on faulty set of assumptions that are not, and likely will not, slow the increasing cost, much less bring it down to a more reasonable level.

We believe that conventional wisdom is wrong, or at least incomplete. The US needs independent physician practices and there can be a bullish outlook for these medical groups in the future.



This paper looks at the promises of, and results to date, of healthcare reform. Both policy and market changes of the past decade have favored organizational size and scale that physicians and medical groups can never achieve. This has caused many to conclude there is no viable role for independent physicians going forward. While we unapologetically confess that we have a pro-independent physician bias, we think that conclusion is wrong. We'll make our case and let you decide for yourself. We think the facts are compelling.

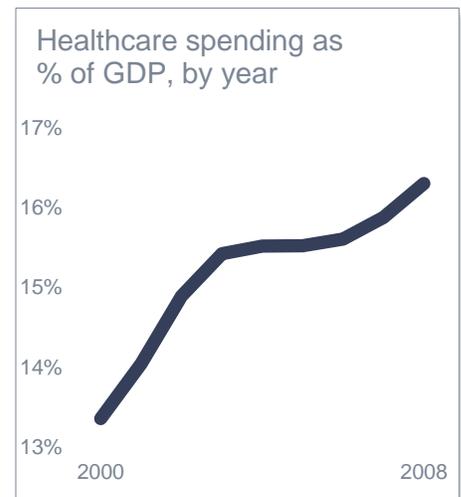
HEALTHCARE HITS THE WALL

In 2000, over a decade ago, the healthcare cost crisis burst fully into the collective American conscious, driving an election and massive changes, both from policy makers and market participants.

- Healthcare spending, as a percentage of GDP, had quickly jumped to over 16% and showed no signs of slowing.¹ Total spending was fast approaching \$2.5 trillion a year.
- Between 2000-2005, healthcare cost increases averaged 7% a year, 2.5 times faster than the general rate of inflation.
- Cost per capita had almost doubled in the preceding ten years and was just shy of \$8,000 per person in 2008.
- The cost of employer-provided insurance climbed to 8.5% of wages even as more cost were pushed directly to employees.

But the public did not need statistics and data recited to them; their paychecks and bank accounts were evidence enough. People knew they were paying a greater percentage of their premium – if they had insurance at all – and shouldering higher co-pays and deductibles, all while getting less coverage.

Something had to change.



THE REFORM PRESUMPTIONS

Reformers, both in government and in the market, quickly coalesced around four big ideas to ‘bend the cost curve.’ Policy changes and strategic decisions all seemed to hinge on these four pillars.

- Insurance coverage: The high rate of the US population without health insurance was seen as not only immoral, but also a major driver of unnecessary costs. Getting more people, if not everyone, health insurance would, in and of itself, drive costs lower.
- Payment for value: All that was wrong with healthcare, it seemed, was ultimately rooted in the fatally flawed presumptions of paying hospitals, physicians and other providers under the fee-for-service (FFS) model. Instead of volume, value-based reimbursement (VBR) was the new future.
- New delivery systems: Closely tied to the FFS scheme, and likely exacerbated by it, was the fractured nature of the healthcare delivery system. The move to integrated delivery systems that had begun in the 1990s must be accelerated. In fact, the goal was to go one step further. The new

¹ Data used throughout (see links to sources at end of paper), unless indicated otherwise:

Population: US Census Bureau

GDP: St. Louis Federal Reserve

Healthcare Spending: Centers for Medicare and Medicaid Services (CMS)

delivery system would not only be integrated; it would have an integrated payment model. Thus, the Accountable Care Organization (ACO) was born.

- **Information technology:** Finally, healthcare had lagged other industries for far too long in the deployment of information technology. Solve that and, as had been seen in other industries, productivity would rise, and costs would fall. Further, two of the big ideas – VBR and ACOs – required advanced technical and data capabilities that the industry did not then have.

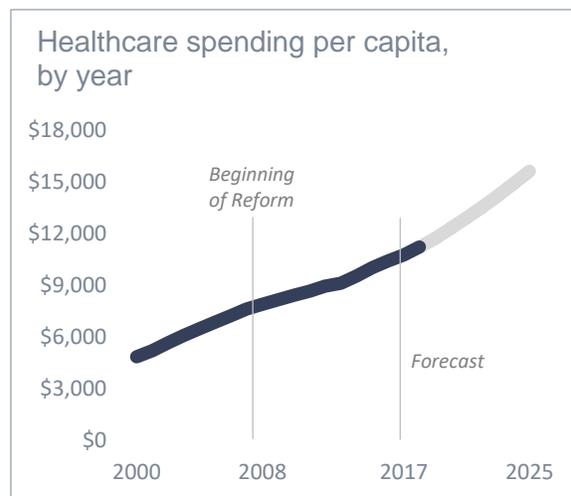
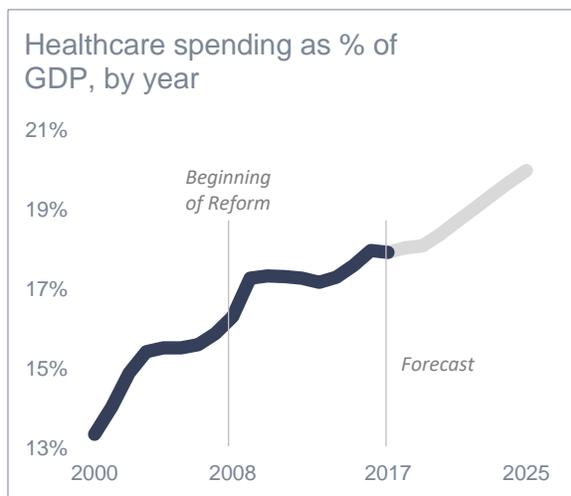
In a nutshell, the grand plan to remake one-sixth of the U.S. economy was fairly straightforward, at least in concept: Get everyone health insurance and then plug them into a new organization that would both deliver all the care and get paid in a different way. Accelerate this all with better information technology. Costs would fall and quality would improve.

PROGRESS REPORT

We are now a decade into wholesale reform, so we ask, ‘Are we making progress solving the problem?’

Headline Results

Virtually endless data could be presented to answer the question, but two measures tell similar stories and at least at the highest level the answer would appear to be ‘not really.’



- **Healthcare spending (percentage of GDP):** This did slow and level out for a bit in the first five years of the reform era before resuming a rise that is not forecasted to stop anytime in the planning horizon from CMS that goes out to 2025. Two factors must be kept in mind when evaluating these data – the great recession corresponded to the start of reform efforts and many policy-level changes were not actually implemented until 2013. Do reform efforts get credit for the temporary slowdown or blame for the resumed climb?
- **Annual per capita spending:** This measure is more linear but ends up in the same general place. Healthcare spending was \$7,900 per person in 2008 when reform efforts began and was \$10,700 in

2017. The growth rate slowed, but CMS predicts it will accelerate even faster in the future.

Neither of these charts suggest that we have made a dent in the cost issue that threatens the economy at large, government spending, corporate competitiveness, and the financial burden on American families. In all fairness, the migration of Baby Boomers into retirement and eventually, the very high cost when more of them become 'frail elderly' absolutely puts upward pressure on these numbers.

But regardless of why, if healthcare costs continue to grow faster than GDP and personal income, as projected for the foreseeable future, the coming implications will be painful.

Government Spending

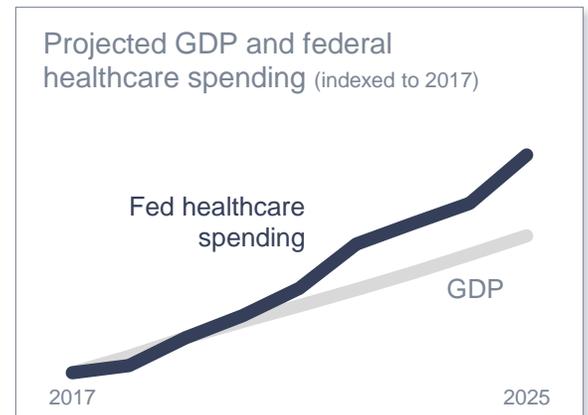
Healthcare costs are a major policy issue because of the amount of public spending it consumes and the impact it has not only on other budget priorities, but also the federal deficit.

- **Federal:** Healthcare programs already account for 30% of the entire federal budget. By 2025 spending will be over \$1.8 trillion, consuming close to 50% of all mandatory spending. Though federal healthcare spending growth is projected to track with GDP growth in the next few years, it again is expected to outstrip the broader economy and continue to rise faster through 2025.

Medicare spending will increase significantly, driven by the aging Baby Boomers, and shows no evidence of expected change in the pace of increase. By 2025, spending on the program will be approach \$1.2 trillion.

Medicaid cost increases at the federal level are expected to steadily increase and approach \$600 billion by 2025.

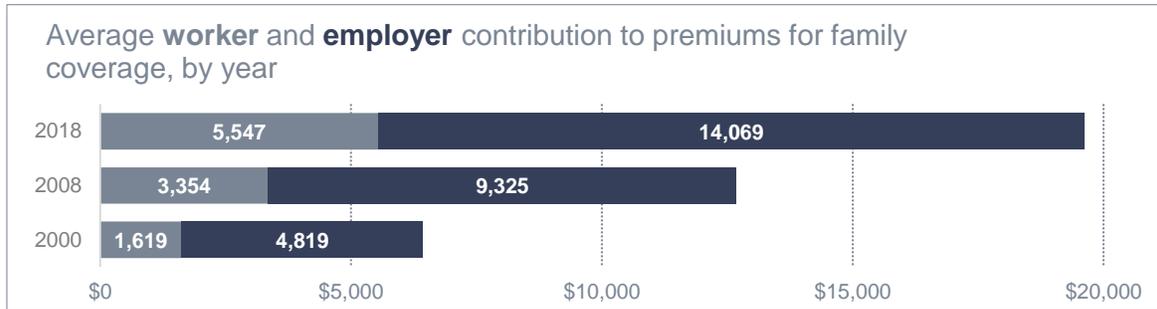
- **States:** That is a small consolation to governors and state budget managers who have seen Medicaid spending jump over the past several years. Actual amounts vary significantly from state to state based on a variety of factors, including whether the state opted to expand Medicaid as part of the Affordable Care Act. Now, on average, over 19% of state general funds now go to Medicaid, putting pressure on other spending priorities such as education and other public services.



Employer-Sponsored Health Insurance²

The cost of employer-sponsored health insurance (ESHI), which provides coverage for half of all Americans, rose 11.1% per year between 2000 – 2005. Since 2013 the rate of family premium growth slowed to below 4%. Yet, the cumulative effect of years of high increases means that the average family plan premium for 2018 was approaching \$20,000 a year.

² Kaiser Family Foundation: Employer Benefits Survey



- **Premiums vs. personal income:** In 2000 the average annual family premium for ESHI was 21% of the average personal income. Since 2009, that ratio has stabilized at around 35-36%, with premiums and personal income growing at roughly the same rate.
- **Cost shifting:** Employees continue to see more and more financial responsibility shifted to them. In 2000, the employee paid \$1,619 of the annual family premium. The employee share in 2018 was \$5,547. 11% of personal income now goes toward premiums. Additionally, employees are paying larger deductibles, which have gone up 212% over the past decade, compared to only a 26% increase in earnings over the same period. 25% now have a deductible of \$2,000 or more.

In Summary...

We have spent a decade, billions of dollars, and an untold amount of energy to ‘remake’ the entire healthcare industry into something that will:

- Increase in cost materially faster than the overall economy for the foreseeable future.
- Consume one out of every three dollars of government spending and drive up the national debt.
- Fail to relieve the financial burden that healthcare places on the poor and middle class.
- Consume an ever-growing portion of family budgets for even those who have the ‘gold standard’ of insurance through their employer.

And this is progress?

FLAWED ASSUMPTIONS

Could it be that the entire reform framework – both policy provisions and various market strategies – is built on a set of well-intentioned, but misguided, ideas? We think so.

Assumption: Getting Everyone Insurance Coverage Will Lower Costs

This was, and remains, the fundamental presumption of reform on the policy side. Economically and morally, reducing the uninsured rate seems to be an obvious goal. But several factors undermine the notion that simply getting people insurance will lower overall costs.

- **Cost and utilization:** Advocates of expanding coverage suggest that people without insurance are less likely to seek preventive services and care for major, chronic conditions. But data supports the simple economic principle that when something gets cheaper, people consume more of it. So why are we surprised that when people get insurance, their utilization of healthcare services increases?
- **Site of service:** It was assumed that with insurance people would move from expensive settings like the emergency room to more cost-effective settings, namely the office of a primary care physician. Growing evidence suggests that simply getting an insurance card does not automatically change patient behavior in where they seek care.

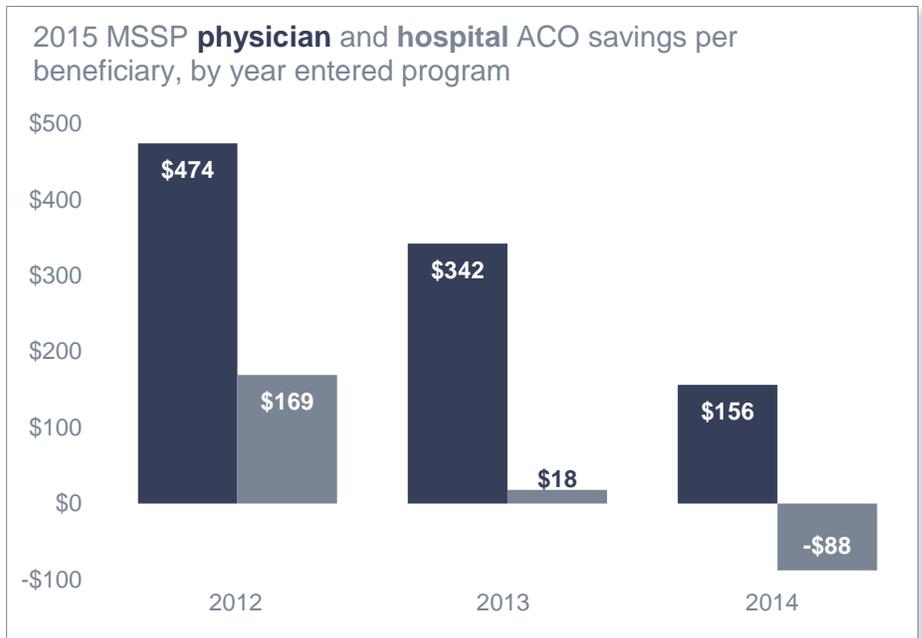
Getting more people covered by health insurance has value by removing the catastrophic financial risk for individual families. But good intentions aside, there is no evidence yet this will lower spending.

Assumption: Paying for Care in a Different Way Will Lower Costs

It seems logical that you get what you pay for – pay for volume, you will get more of it. Therefore, paying for value instead should reduce costs. Maybe eventually, but data to date are mixed at best.

Central to the government move to VBR was the ACO and CMS pushed this model via the Medicare Shared Savings Program (MSSP). A 2018 study of MSSP ACOs³ found:

- Physician-centric ACOs have higher savings rates, per beneficiary, than do hospital ACOs.
- Savings increase the longer the ACO has been in the program, but physician ACOs start with more savings year one (hospital ACOs initially increase costs) and improve faster.



- Physician ACOs cover less than half of the beneficiaries than do hospital ACOs (1,850 vs. 4,000).
- Net savings from in physician ACOs produced a benefit to Medicare of \$256 million in 2015, whereas spending reductions in hospital ACOs were offset by their bonus payments (no savings).

Though early, ACOs have not yet demonstrated they are the answer for moving the cost needle, and where they are, physician owned and led ACOs perform better.

³ The New England Journal of Medicine

Other elements of VBR – readmission penalties, bundled payments, MACRA, quality payments – are either small or are having difficulty scaling up. They may be good ideas, but thus far have shown no clear evidence that they will materially change the large trends.

One area where the move to VBR has been significant is the growth in Medicare Advantage and various managed Medicaid programs. This is somewhat ironic given these are essentially repackaged old-fashioned capitation models.

Assumption: Integrated Delivery Systems Will Lower Costs

Hospital-based health systems consolidation has increased in recent years, a strategy, reported by their executives, directly in response to reform.

- According to the American Hospital Association, over two-thirds of community hospitals are now part of a health system.
- A 2017 Health Affairs study found that 90% of the Metropolitan Statistical Areas (MSAs) were highly concentrated for hospitals.

Your assumptions are your windows on the world. Scrub them every once in a while or the light won't come in.

Isaac Asimov

But rather than deliver efficiencies that lower costs, the consolidation has led to monopoly pricing power and a significant increase in costs. The body of evidence that could be cited to validate this claim is overwhelming, but to cite just one, another Health Affairs study published in February 2019 found:

- From 2007-2014, hospital prices (the amount actually paid on negotiated commercial contracts) increased by 42%, while physician prices grew by only 18% over that time.
- Similarly, hospital-based outpatient prices increased by 25% vs. 6% for physician practice outpatient services.

Economic reality is proving to be just the opposite of what reformers envisioned.

Assumption: Employed Physicians Will Lower Costs

Monopolistic pricing leverage is not the only economic issue with integrated delivery systems. The other is the employment of physicians by hospitals and health systems. According to Avalere Health and the Physicians Advisory Institute, in 2012, about 25% of all physician worked for a hospital or health system. That number jumped to 44% in 2018. This particular form of 'integration' increases costs in several ways, but the most direct is the 'site of service differential.'

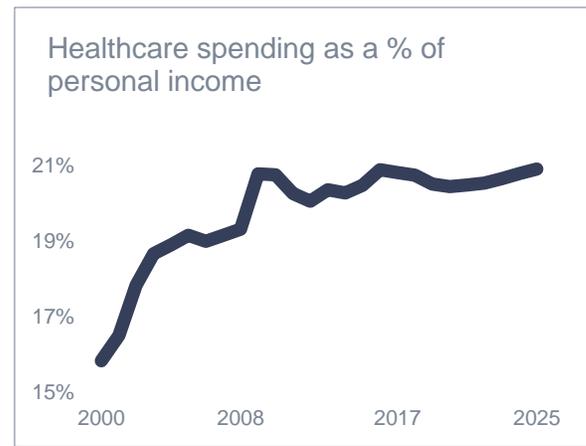
- Both government and commercial payers reimburse for ambulatory and outpatient services using different fee schedules depending on the type of location in which the care is delivered. One rate is paid for a service provided in a physician office, but if that physician is employed by a hospital, the payer pays twice – once for the physician and once for the facility.
- The non-partisan Medicare Payment Advisory Committee (MedPAC) that advises Congress found that a Level 3 outpatient visit which would be paid \$73.08 if conducted in a physician office, cost \$144.11 if the physician is employed by a hospital, a 2x increase.

- Diagnostic tests are also higher for employed physicians because they, too, are now paid according to the hospital outpatient department (HOPD) fee schedule instead of the physician office rates. MedPAC found that CMS was paying 141% more for a Level 2 echocardiogram performed in a HOPD than one performed in a physician office.

The Flaws Exposed

The most fundamental assumptions upon which healthcare reform is based do not reduce costs at all, at least not yet.

- Getting more people insurance increases utilization and does not necessarily move care to lower cost settings.
- Paying for value instead of volume may reduce costs eventually, but that road will not be easy.
- Encouraging hospital mergers, as the ACA seemed to do, increases monopoly pricing more than it delivers economies of scale.
- Employing physicians by hospitals just moves their services to a higher cost fee schedule, with no discernable increase in value.



THUS, THE OPPORTUNITY

The facts and data suggest the changes to date either fail to address the issue or, in some cases, even make it worse.

But how does this necessarily translate to an opportunity for independent medical groups?

Each practice must develop its own specific strategy for how to compete and win in this new environment, but three big ideas should inform that strategy. These will help lower the overall cost and improve healthcare. Each play directly to the strengths of independent practices. Those who can do these will be well positioned for the future.

- Drive out pricing inefficiencies: An unnecessary part of the high cost is due to significant pricing inefficiencies, situations where the price is higher than it should be for no reason that serves the customer or delivers value. In all fairness, some physician groups currently benefit from such pricing, but this is more pronounced for integrated delivery systems.

This is the opportunity for independent physicians – because of a lower cost structure they can deliver comparable services at price points below that of hospital systems. As one proxy for the level of inflated pricing, the Office of the Inspector General estimated that Medicare could save \$15 billion over about five years if it simply applied the ambulatory surgery center rates to low-risk outpatient surgeries performed in hospitals.

Price compression is now happening fast. New market entrants, enabled by technology and

unencumbered by legacy costs, are attacking pricing inefficiencies with a vengeance. These innovators threaten all incumbents, including physician practices, who do not respond.

- **Make different decisions at the point of care:** High unit costs are only part of the problem. The other half of the cost equation involves the decisions of what care treatment to use and how it will be delivered. There are many treatment decisions that lead to either efficiency or wasteful care. Examples of waste – excessive imaging studies that will not alter the course of treatment to expensive end-of-life measures that provide no value to patients and their families – all begin with decisions made at the point of care. Once a care decision is made, where that care will be delivered also has a dramatic impact on the cost.

No one in the industry is better positioned than physicians to intervene and help patients make better decisions about the ‘what’ and ‘how’ of their care. Independent physicians have an advantage in that they can far more easily direct care to lower cost settings than their employed colleagues.

- **Innovate faster:** The data cited in this paper make the case that healthcare must change faster and more fundamentally. Yet, because many functions require large amounts of capital that only big organizations can accumulate the industry is dominated by very large organizations – government, payers, health systems, pharmaceutical and device manufacturers.

But innovation is most frequently executed by smaller, nimbler organizations before it is normalized by larger players. This, too, fits the inherent strengths of independent medical groups.

What It Takes

Despite the obstacles physicians face, we unabashedly believe there is a viable and positive future for practices who choose to take it. This will not be gained by futile attempts to return to the past. The world and the rules have changed dramatically. Physician practices that seek to remain independent and in control of their destiny must respond accordingly. Three elements are required for success:

- **Leadership:** It may seem trite to put leadership at the top of this list of requirements, but that does not make it less true. Physicians, particularly independent-minded types who find this message compelling, need to be led in a very specific way. They are strong personalities whose name is on the door and whose license is on the line. They do not countenance leaders who have not earned their trust. A blend of both physician and executive business expertise is required for success.
- **Scale:** Independent does not mean small. Regulatory and competitive burdens make it increasingly difficult for small practices to survive. There are many considerations that define how big is big enough. On one hand, scale drives market presence and leverage – payers, employers and health systems simply respond differently to groups with more relative size. But a more tangible answer as to how big a practice needs to be is based on its ability to invest to compete – in talent, technology, marketing, service line expansion, the patient experience – in all parts of the business.
- **Boldness:** Navigating an industry where the rules are slanted toward larger players is not for the faint of heart. Further, independent physicians face the reality of investing their own money – literally – instead of someone else’s capital. It is understandable when caution gives way to paralysis. Yet, timid responses by physicians will allow the inertia of the industry to continue to flow toward, and then calcify around, large bureaucracies. Waffling and incrementalism will not work.

CONCLUSION

We harbor no naïve illusions that things will be easy for physician practices that choose to remain independent. But the fact remains that we must remake U.S. healthcare into something more sustainable or we will face alternatives that are even less attractive for everyone. Economic gravity eventually wins and things begin to break. The market will demand better solutions. Fortunately, the fundamental changes that are required are things that independent physicians do well. It is for this reason that we are bullish on the future of those groups that rise to the challenge.

KEY DATA SOURCES

GDP	<ul style="list-style-type: none"> - Actual – St. Louis Fed: https://fred.stlouisfed.org/series/GDP#0 - Projections – Congressional Budget Office: https://www.cbo.gov/about/products/budget-economic-data#4
Healthcare Spending	<ul style="list-style-type: none"> - Actual to Date (through 2017) – CMS: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html - Forecast (2018 – 2025) – CMS: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
Other Sources	<ul style="list-style-type: none"> - American Hospital Association – Fast Facts on US Hospitals, 2019: https://www.aha.org/statistics/fast-facts-us-hospitals - Health Affairs – Health Care Market Concentration Trends In The United States: Evidence And Policy Responses: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0556 - Kaiser Family Foundation – Employer Benefits Survey: https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/ - New England Journal of Medicine - Medicare Spending after 3 Years of the Medicare Shared Savings Program: https://www.nejm.org/doi/10.1056/NEJMsa1803388 - Physician Advocacy Institute – Physician Employment Trends: http://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment

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