

PeRspective

THE “PHYSICS” OF MARKET CONSOLIDATION AND THE LIKELY EFFECTS ON THE PRIVATE MEDICAL GROUP PRACTICE



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Physicians and health system executives can intellectualize the macro-economic pressures of health care in the U.S. The question is: Do they fully appreciate the “stored energy” of these pressures; and when released, how the provider side is affected and with what speed?

The premise defended here is that the provider side of the U.S. health care system is under tremendous and irreversible pressure to consolidate; the likely result is more complex, integrated systems of care.^{1,2} The reality is that this premise is no longer simply an interesting intellectual debate. The mainspring is being wound. The arguments for this position follow.

Notable Facts and Observations About the Payer Side.

The commercial payer side of the U.S. health care system has now consolidated to a very strong few who have significant cash reserves and designs on better cost and utilization management.

Upwards of 58% of the total U.S. Health Benefits market now rests with nine organizations. Non profit and mutual Blue Cross and Blue Shield plans own the lion’s share of that (31%).³

Medicare and Medicaid hold responsibility for 42% of the total market of “covered lives”. CMS projects that by the year 2020 all fund reserves are exhausted unless policy or tax appropriations change.⁴

The percentage of citizens covered by employer-funded health plans has decreased from 69% in 2000 to 60% in 2007.⁵

The estimated number of uninsured is growing and the estimated number of non-elderly encouraged to purchase individual health insurance policies has grown as well.

The “stored energy” on the payer side of the health care industry should lead to predictable market behavior and pressures:

- Continuing downward pressures on price and utilization;
- Transfers of financial risk to customers (patients); and
- Transfer of financial risk to providers

Notable Facts and Observations About the Provider Side.

Independent physicians, whether organized in small or large, single specialty or multispecialty groups operate from “thin” and vulnerable revenue streams supporting daunting operating expense inflation rates and overwhelming capital demands. The anatomy of the revenue streams of most medical group practices, aside from professional fee revenues, are composed of a relative few services with eroding margins; typically imaging services, laboratory, and outpatient procedures. Payers, especially the governmental, are “surgically” reducing these margins; e.g., imaging services, outpatient surgery, endoscopy, etc. The effects of these reductions on physician compensation are likely to be pronounced and swift. Add the capital demand load of the electronic health record, other information systems technologies and advancing clinical technologies and once robust medical practice business models are weakened to the point of collapse, for some.⁶

Hospitals and hospital-based health systems are under pressure from several perspectives: downward pressures on reimbursements; operating expense inflation rates that exceed “per unit” reimbursement revenue inflation rates; market share wars with competitors; and medical staff-affiliates importing the more profitable ambulatory revenues (and inpatient revenues) in attempts to compensate for the dynamics described above. Add to it accelerating capital demands for specialized inpatient and outpatient facilities, the electronic health record and clinical technologies and the economic admixture is challenging at best. Overlay the risk of failing business models of affiliated physicians⁶ with the related costs of practice acquisitions by health systems or costs to health systems of disintegrating practices of affiliated physicians and the strategic landscape changes quickly. All the above is a textbook recipe for provider side consolidation, hospitals and physician integrating their businesses. Now back to the beginning; consolidation of the provider side of U.S. health care is more than a “straw man” open to intellectual debate.

What Does All This Mean?

Most of the pressure to consolidate (integrate) will come from the physician side of the provider equation because the effects of the pressured dynamics appear relatively faster (by comparison to hospitals) largely due to the dynamics of the medical practice business and financial models. Most do not retain financial reserves sufficient to fund a “bridge” from one business cycle or business model to another, and physicians aren’t likely to remain in under-producing business models for long when alternatives are presented. When the economics of the medical practice are negatively affected, the deterioration of the business model can follow quickly.

What Are the “Forces” Encouraging Physicians to Move to New Business Models and Where Do They Come From?

Cynics on the hospital side of the business will observe the economics of the physician side and others respond with “Well, they’ll just have to live on less”. Alternatively, health systems who are willing to move markets with novel and innovative integrated business models will see these economic conditions as a buying opportunity; an opportunity to destabilize traditional markets at an even faster rate by encouraging integration of physicians through the purchase of medical practices. Markets move quickly under these conditions. The strongest balance sheets typically win.

Didn’t Hospitals Try This Already? Didn’t They Just Lose Money?

Yes, hospitals have purchased medical practices before; typically primary care, and yes, most lost money on practice operations. It’s different now. The large group practices and the single specialty groups are integration candidates. Specialties within each of these group practice business models drive most of the profitable revenues for health systems; cardiovascular, orthopedics, neurosurgery, cancer care and, other surgical and procedural specialties.

Won’t hospitals that integrate with physician specialists simply lose more money faster? Faster than what? Not having them available at all? Losing money with integrated health care delivery models is not a *fait accompli*.

It is possible to manage operating economics effectively in integrated models of health care delivery. At least with integrated models of delivery all are in the same economic boat. Integration eliminates (or at least minimizes) the risk of the “independent medical staff” evaporating overnight, or competing.

Health system leaders owe it to their organizations to look objectively at the vulnerability of the physician practice business models they rely upon for the future of their organizations. Moreover, no medical practice design is immune to the market. No health system executive can justify a loss of a highly valuable group of physicians by claiming he or she didn’t know they were at-risk.

¹ Zismer, D.K., Person, P.E.; “Integrative Specialty Care: Pursing a Convergent Path with Medical Staff”, *Healthcare Executive*, July/August 2006.

² Zismer, D.K., Person, P.E.; “Are Community-Based, Not-for Profit Health Systems a Threat?” *Group Practice Journal*, February 2008.

³ Citigroup Investment Research, “Health Insurance: Our Analysis of the Individual Market Opportunity” (September 13, 2007).

Returning to the Analogy of the “Stored Energy” and its Effects When Released. How is the Potential Evaluated?

Many of the single and multispecialty medical group practices have been doing their best to stave-off the inevitable. The effects of these efforts are evident in an analysis of the financials; diminished spending on capital assets, increasing operating and capital debt loads (including lease obligations), pressures on physicians incomes and attempts to hold down operating cost inflation rates. What is not evident on the financials is equally important: pressures contributing to the “physics” of the dilemma practices are experiencing, including growing challenges to recruiting new talent; health systems are out-bidding practices for physicians, traditional and unattractive practice buy-in models discourage potential recruits as does a lack of state-of-the-art practice-related technologies. The pressure of these factors builds and the energy is released. A decision to “sell” appears to be precipitous to external observers (typically health system executives) as well as to many of the internal stakeholders (employees of physicians). Regardless of the reaction, the result is the same; a need to do something different and quickly.

Health system executives are often caught off-guard. There is need to mobilize quickly or face loss of valued specialty physicians. To respond requires:

- Dedicated time from senior leaders;
- Guidance from these with experience “in the trenches”;
- Balance sheet capacity to afford the required practice asset acquisition costs as well as the hard asset investment and working capital needs of the group(s) acquired;
- An organizational structure and capacity to accept and operate medical group practices;
- A plan and capacity to manage the broader medical staff politics that ensue (including at the Board level);
- A strategy to optimize the potential of the related practice acquisition(s); e.g. growth, subspecialization, geographic distribution and clinical program development.
- An organizational structure that allows integrated physicians the opportunity to use their potential to its highest and best use including as “co-managers” of specialty services and clinical programming.

Stated simply, when the “stored energy” releases, the affected health system must be prepared to act. The moral here is it is better to expect and prepare than be surprised. Senior health system executives should dedicate the time required with leaders of key, affiliated medical groups to thoroughly evaluate and appreciate the status of the “stored energy”.

Are There Alternatives to Integration of the Multispecialty and Specialty Group Practices?

Some senior executives appreciate and buy-into the risk, but not the solution: “We’ll need to do something, we prefer partnerships and arrangements that solve the problem, but don’t require full integration. We don’t want to employ the specialists”. While this position is understandable it’s becoming less practical. The regulatory environment is less likely to tolerate the wide range of “deals” seen over the last decade, leaving less joint venture and contractual options available and the array of the more typical partnerships and contractual arrangements won’t be sufficient to fix the problems that are driving consolidation.

The “efficiency” of the relationships with specialty physicians is enhanced proportionate to the degree of integration achieved. Practical experience in this regard demonstrates:

- Service-line-specific contractual arrangements do not address the whole of the independent practice business model risk;
- It’s challenging to engage and compensate independent physicians as co-managers of key service line and related strategies;
- Long-term stability and recruitability of a key specialty practice is not assured through one or several health system “deals” that likely have prescribed term lengths.

Summary

Like it or not, U.S. health care market dynamics are pressuring the provider side to consolidate. Independent physicians are especially vulnerable. Large and small practices are affected. Clinical specialties critical to the financial and strategic success of health systems may be at the highest risk.

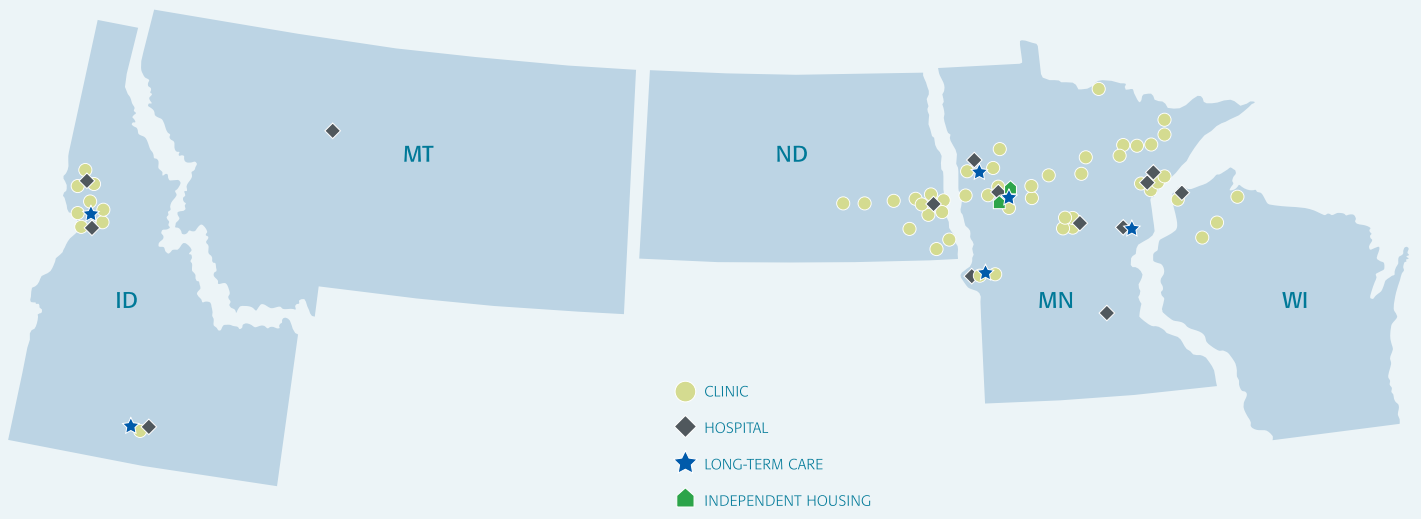
Consequently, the hospitals and health systems that rely upon a steady and stable supply of physician specialists to meet mission, strategic and financial goals should be mindful of the mounting business risk. Health system executives must appreciate how quickly the “negative energy” stored by independent medical practices can be released causing key, affiliated specialty medical practices to: disintegrate, compete or seek affiliation or integrate with competitors.

⁴ Source: Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2007.

⁵ Cain Brothers, Strategies in Capital Finance, “Farewell to a Time of Plenty”, Vol. 56, 2008.

⁶ Zismer, D.K., Person, P.E.; What Does the Future Hold for the Larger, Independent, Multispecialty Medical Group? Is a “Tipping Point on the Model’s Horizon? Group Practice Journal, April 2007.

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