Strength in Numbers:
How Physicians Can Remain Independent

by Joseph E. Huigens

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The growing trend of physicians moving out of independent practice to become employees of larger health systems and hospitals is nothing new in the eyes of a health lawyer. But it doesn't take a lawyer to recognize the negative effects that this trend might have on physician practices and quality of care. It is important to recognize the reasons behind this trend and identify ways that physicians can still remain independent in order to maintain autonomy and provide better access to care for their patients. The truth is that it is not as difficult for physicians to remain independent as some may think. Identifying the resources available to physicians involves strategic planning with a trusted advisor. With such assistance, physicians are empowered not only to remain independent but to thrive as well.

An Attack on Independence

Perhaps the most recognizable force causing physicians to leave independent practice is poaching and consolidation of physicians by large health systems and hospitals. In 2018, for the first time ever, the number of physician employees outnumbered independent physician owners of a practice.[1] Health systems and hospitals are taking advantage of their greater bargaining power and essentially making job offers that physicians may think are too good to refuse. However, there are concerns with this uptick in physician consolidation by large health systems.

Antitrust law is playing a role in keeping at bay this wave of consolidation and physician recruiting. When a hospital acquires a practice, this is treated as a merger between the two entities and can have an effect that reduces competition in the relevant market. The Clayton Act and the Sherman Act[2] both come into play when considering whether antitrust law is applicable to this common scenario today. But it is not just the merger that causes antitrust issues. A disconcerting new trend among hospitals is to withhold medical staff privileges from physicians who are not employed by the hospital or hospital system. Without diving into a deep analysis of this practice, it is easy to see how such a practice may trigger antitrust scrutiny as it arguably forces physicians to succumb to the larger entity's bargaining power, wiping out practices that create healthy competition.

Another issue is the recruiting disadvantage faced by independent physician practices and the relationship that this has with fees and reimbursement. With greater bargaining power and resources, hospitals are better able to recruit physicians by offering higher salaries and overall compensation. This leverage is compounded with the fact that reimbursement rates have not changed for the physician services category as compared to other service categories.[3] With disproportionately lower reimbursement rates for physician practices, it is hard to imagine how smaller practices can justify the added expenses of hiring additional providers. Additionally, the introduction and transi-

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tion to "value-based care" further exacerbates this issue, because smaller groups are unable to transition as easily and as quickly as bigger systems and often times lack the resources necessary to take advantage of such programs.

The COVID-19 pandemic has only enhanced these hardships. The pandemic has caused reduction in revenues across in the board in health care. Additionally, the moratorium on elective procedures and shut downs for certain providers left some practices out to dry while bigger systems and hospitals were able to maintain (if not expand) their workflows. Each of these issues presents unique challenges for independent physician practices. Taken together, it shows how maintaining independence as a physician practice can be a real struggle in today's healthcare industry.

Pushing Back

Not all hope is lost for independent practices. There are alternatives and solutions that can be leveraged to maintain independence while battling against the disadvantages that physician practices face today. One such option is to form multi-specialty practices or "super groups." This may seem like an oxymoron; however, through smaller scale transactions (e.g., group practice mergers and practice asset sale/purchases), multiple physician practices can create a larger entity that picks up the slack where a single practice could not.

There are definite advantages to this solution. Multi-specialty practices are able to develop real economies of scale and improve quality and efficiency in their market by joining forces. Further, this provides entities with a way to engage in joint contracting with health insurers to negotiate prices in a similar fashion that hospitals and larger health systems can. It also provides additional resources for the practice to utilize to keep up with the changing landscape in healthcare. For example, forming a super group may give the entity the ability to better aggregate data to show physician performance—a key function in order to facilitate the transition to value-based care.

While it may seem that joining forces could lead to less independence, the physicians still have the ability to determine—amongst themselves—their desired level of control through the governance structure of their new, larger group. That said, some challenges are likely to arise with this solution. First, compensation issues tend to become a point of contention between physicians practicing together in a multi-specialty group. It is important to identify which functions each physician will have and how those functions contribute to the overall management and success of the practice. Maybe more importantly, all the physicians in the larger group need to understand that differing specialties are compensated at different levels. The mere fact that a family practice physician joins a multi-specialty group of surgeons does not mean the family practice physician will suddenly be compensated at the same level as the surgeons. And, of course, it is important to abide by the applicable regulatory requirements. The Stark Law and Federal Anti-Kickback Statute have specific rules to be followed when working with compensation and group practices.[4]

Other Options

Outside the context of super groups, there are a wide variety of more specific arrangement models that are available to physician practices. An option for some specialty groups is to add an ambulatory surgery center (ASC) to the practice. ASCs allow physicians to provide surgical services to patients who do not require hospitalization and where the duration of services would not exceed 24 hours following admission.[5] ASCs can provide more personalized care for patients that hospitals may not be able to provide while potentially reducing costs for the patient.

Previously, in Nebraska, an ASC was defined as a facility where surgical services are provided to persons not requiring hospitalization and who are admitted and discharged within the same working day. In other words, Nebraska ASCs could not keep patients past midnight of the day on which they were admitted. However, in November 2020, the Nebraska Legislature changed the definition of an ASC to match the definition Medicare uses.[6] Now, Nebraska ASCs can allow patients to stay overnight as long as they are discharged within 23 hours and 59 minutes of their admission. This recent change gives Nebraska ASCs greater flexibility in their practices and may allow other providers to participate in the advantages of forming and operating an ASC.

Accountable Care Organizations (ACOs) are another strength-in-numbers option available to physician practices. ACOs are groups of physicians, hospitals and other healthcare providers that coordinate care for their shared patients in tandem. By working together in coordinating care, the participants of an ACO should achieve cost savings and may be able to share in such savings through the Medicare Shared Savings Program (MSSP). There are specific eligibility requirements for providers to participate in an ACO and the providers must execute agreements with the Centers for Medicare & Medicaid Services (CMS) in order to participate.

Somewhat similarly, physician practices can join Independent Practice Associations (IPAs) and Group Purchasing Organizations (GPOs). IPAs are networks of physician practices that can be organized amongst a variety of providers in different specialties. IPAs are formed in order to achieve cost savings through, for example, reducing overhead expenses or pursuing business ventures that single practices could not otherwise pursue on their own. IPAs can also utilize and participate in other models, such as ACO agreements or health maintenance organizations.

GPOs allow multiple practices to join together when purchasing healthcare products and services. Essentially, GPOs are high volume-based buyers. GPOs take advantage of their higher bargaining power to negotiate discounts and, thus, reduce costs of the specific items and services available to GPO members. Both IPAs and GPOs can help physician practices to maintain their independence while also engaging in a collective effort to achieve economies of scale without undergoing a merger or asset sale/purchase transaction. As might be obvious, when structuring IPAs and GPOs, antitrust, fraud, and abuse regulations become a forefront concern, and careful organization, structuring, and operation of the arrangement are paramount.

Actions That Can Be Taken Today

If committing to any option described above is overly time consuming or simply not in the cards for a practice, there are still other steps that can be used today to help maintain independence. One such option is to take full advantage of the Medicare Physician Fee Schedule.[7] The current physician fee schedule provides numerous expansions of services that can be furnished through telehealth. Private health insurance plans are also increasingly covering such services. CMS and private insurers have recognized the increased need for telehealth services due to the COVID-19 pandemic. Additional services that can be provided using telehealth may offer physician practices new revenue streams with limited upfront investment.

Additionally, the Medicare Physician Fee Schedule now allows non-physician practitioners (NPPs) to supervise diagnostic tests.[8] Prior to the COVID-19 pandemic, NPPs were able to order and perform diagnostic tests but had to be supervised by a physician. In response to the pandemic, CMS temporarily waived the supervision requirement. However, the latest physician fee schedule makes that temporary waiver permanent. The result is that physician practices can now use their NPPs more freely than in the past with respect to such tests. This may give some practices the ability to fill their staffing needs with a different mix of physicians and NPPs and help alleviate the recruiting disadvantages that practices face today. Moreover, in Nebraska, nurse practitioners can practice independently. Levering the services of qualified nurse practitioners is yet another option for smaller practices looking to expand to a wider market—especially in rural areas.

Finally, it is important for physician practices to understand that it is nearly impossible for physicians to wear all the hats in a practice. Seeking expert help outside the world of medicine is a critical step that needs to be taken in today's ever-changing healthcare landscape. Experts in practice management and business support can help ease the administrative burdens on physicians. More specifically, experts within the health information technology industry are going to be needed, especially with the push towards interoperability and rules on information blocking.

Conclusion

The ability to maintain independence still exists for physician practices despite recent challenges. The key is for the practice to take action by seeking help, whether it is through forming a super group, levering other practice models, or engaging with outside experts. No matter the steps taken, it is important for legal counsel to be involved and help guide physicians through the regulatory landscape towards achievement of the practice's goals. The overall focus should be to give physicians the ability to concentrate on delivering top-quality patient care while achieving cost savings and providing sufficient access to their patients.

Endnotes

1 Carol K. Kane, PhD, *Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees*, Am. Med. Ass'n (May 2019).

2 15 U.S.C. Ch. 1.

3 *See* CMS, *FFS Trends*, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends (last accessed April 12, 2021).

4 *See generally* 42 C.F.R. §§ 411.352 and 1001.952.

5 *See* 42 C.F.R. 416.2.

6 Neb. Rev. Stat. § 71-405.

7 *See* 85 Fed Reg. 84472 (Dec. 28, 2020).

8 *Id.*