The Developing Crisis in Solo/Small Group Physician Practice in California: Implications for Hospitals and Access to Care

By Walter Kopp, President, Medical Management Services

California is clearly headed for a crisis in access to physicians. Not only have the pressures of managed care hit the physicians hard, but the old structure of the solo physician entrepreneur is dying. Based upon our interviews with physicians and review of recent data, it is becoming clear that many new physicians do not want to start a practice but want a job where they can focus on the clinical aspects of care and not be burdened by the risk of managing a business. As this change has evolved, some communities in California are beginning to experience access problems because many physician groups do not have a structure to offer new physicians a job, and because of the high cost of living, of starting a new business and of buying into an existing practice. Physicians are going to organizations that can offer them a job and stability. Because there are few succession plans for physicians who are near retirement, access to Physicians is reaching a crisis not only in traditional areas like rural and underserved communities, but also in some of the most affluent communities in the state where physicians can not afford to purchase a home based on the income they can obtain from traditional compensation model.

Many retiring physicians in community hospitals in California are discovering that there is a dearth of interested buyers for their practices and in some cases there is nobody who will take over the practice and care for the patients at any price. This has resulted in fewer choices in some communities for patients seeking new physicians. The scarcity of physicians in some communities is causing extended waiting periods for patients seeking care. Frustration with the current system has resulted in some physicians and their patients moving to Kaiser Permanente and other integrated groups where they can obtain stable work like Palo Alto Medical Foundation .Last year Kaiser Permanente recruited over 500 new physicians in Northern California alone. Almost half of these physicians were "refugees" from small groups and solo practices who were frustrated with the current managed care system and were looking for stability and a place to work that is viewed by some as more friendly to Primary Care Physicians. Kaiser was viewed in the past as a low quality option. This opinion has changed among patients and physicians alike. While not perfect, Kaiser offers significant advantages to the current problems that face the non-Kaiser healthcare market. The Permanente Medical Group has attracted many of the recent graduates and has required their new physicians to be board certified.

Access to physicians is quickly reaching a crisis in some of the urban communities in the state where physicians cannot afford to purchase a home based on the traditional compensation model. The average cost of a house in California is 38% higher than the national average. The difference is greater in some communities. The cost of living is 36% higher than the national average. The average income of solo and small group practice physicians is 23% less than the national average. This significant and growing difference makes it increasingly difficult for communities to recruit new physicians. This difference is more pronounced in some communities where the cost of living is

significantly higher and the penetration of Managed Care is higher. Many communities that have an under supply of physicians, have had to offer income guarantees and housing assistance to get physicians to open a practice.

How this may affect your community

It is our belief that the aging of the physician population and the lack of succession planning may result in significant access problems for patients in the next few years. Hospitals that do not have a plan for addressing these issues are finding themselves increasingly vulnerable to physician shortages that can significantly affect admissions.

Recent studies have indicated that there is an over all adequate supply of physicians but when you look deeper into the numbers and talk with the physicians currently in practice you see a significant problem in some communities. Physicians frustrated with their compensation and with the pressures of managed care are dropping out of IPAs and other managed care plans. They are limiting their practices, closing their practices to new HMO patients and retiring earlier than expected. If you study this from the patient access perspective we are finding significant waiting periods for physician office visits. In some cases patients are being asked to wait up to 2 weeks for routine care and 8 months for a physical exam.

In working with hospitals, we know that many are frustrated with their failed efforts to help physicians. At the same time many hospitals understand that measures are needed to stabilize their physician community to provide for the care of their patients. Hospitals also understand that they must play an active role in assisting the transition of retiring physicians leaving and new physicians coming to their community. They are willing to help, but they do not want to be a "blank check" for the physicians and they do not want to destroy the incentives for the physicians to build strong practices.

Why integrated groups like Permanente and PAMF are winning.

Integrated groups provide a PCP-friendly environment with better pay, more stability, better call arrangements, better retirement and housing support. This gives physicians more control of patient care. These groups have a higher ratio of PCPs resulting in a PCP dominated model. PCP's are paid more in integrated groups and specialists are paid less. Integrated groups have a system for managing care with the use of NPs and other physician extenders allowing physicians to focus on the sickest patients and to leverage their services and time in a more efficient and effective way. Integrated groups also have a seniority system that compensates physicians for their experience and stability.

Community hospitals that have failed at previous attempts to build integrated groups are forming transition clinics. These clinics are formed as departments of a non-profit hospital under 1206a or 1204d of the Health and Safety Code. The hospitals are allowed to establish these clinics to assist physicians who are retiring and offer them payment for time worked. These groups do not pay for "goodwill" and do not pay salary guarantees.

They provide a stable transitional group that helps the physicians while providing access to care for the public.

Succession Planning

In the past, attempts by hospitals to manage integrated groups have failed primarily because they have attempted to control and manage these groups. Hospitals attempting to compete with for-profit physician management companies overpaid physician practices and placed them on salary guarantees, which removed their incentive to work hard. Hospitals are learning from these past experiences and are recognizing that the current threat to their viability is their lack of a structure to hire physicians and of the consequences of physicians retiring without succession planning.

Hospitals should analyze what makes integrated groups successful and create an environment that will encourage these groups to flourish. Hospitals can encourage and help sponsor integrated groups, but should not attempt to operate or control them. They need to assess how they can become competitive in today's environment and evaluate how vulnerable their primary care base is to erosion. Hospitals need to be proactive in evaluating when physicians will retire or when practices will be transferred and develop a succession plan for these physicians and practices.

While hospitals should avoid managing these groups, they need to establish linkages with the Physicians to maintain their referral base. Hospitals can assist with infrastructure support to the Physicians. They have many legal ways to help Physicians with recruitment, housing support, billing support, and preferential capitation payment arrangements. These are not steps that are easy for hospitals to take, but if they are going to assist their Physicians they need ways to help them make this transition.

Kaiser Permanente in Northern California poses a current threat to many hospitals here because they have begun to recruit non-Kaiser physicians. In Alameda for example, Permanente recently recruited 11 of the 16 PCPs in that community. This group moved to Permanente and is moving their patients to Kaiser. Permanente also allowed the physicians to continue to see their Medicare and Indemnity patients. This change in their approach poses a threat for many hospitals.

The recent issue of financial solvency reports for Medical Groups in California by DMHC has highlighted problems with some marginal IPAs. The physicians in these groups are also having difficult problems. As these IPAs are forced to solve their financial problems, many of them will not survive. Since the physicians are often the largest creditors they will be hurt the most when these groups fail. As many of the PCPs are capitated, their movement from capitation to Fee-for-Service payment will put an added cash flow strain on these already weak practices. Some of the stronger groups are growing from these changes and in some cases they provide a cash flow advance to help with this transition.

Kaiser has also benefited from this change. As the patients and the physicians look for more stability they are increasingly looking to Kaiser. Some of the integrated group practices and foundations have picked up some of this volume, but these do not exist in many communities. Some IPAs have been successful in providing stability and a good practice structure, but many are experiencing financial difficulties.

Why you must do something now

We are concerned that hospitals have become frustrated and complacent with these trends. They know that this may result in health care access problems in the future, but they are not willing to make this a priority now. We believe that hospitals that continue to ignore this issue will eventually end up with physician shortages, which can negatively impact admissions and ancillary services.

We encourage hospitals to assess these issues and to develop succession plans for all of their physicians. We have worked with several hospitals to help them make these assessments and have developed the following list of DOs and DON'Ts for work in this area.

DOs and DON'Ts for Hospitals trying to help physicians

DOs
Invest hospital capital dollars in physician succession planning
Develop a succession plan for each of your physicians and practices
Evaluate the health of your medical community. Know the retirement plans of your older physicians
Build linkages with your physicians with Information System infrastructure
Assist with physician recruitment programs including; paying for recruitment and providing income guarantees for the first years and housing assistance
Support the documented needs of both PCP's and Specialists
Support independent but interrelated linkages (like Kaiser and Permanente)
Help practices with practice evaluations and management support
Reduce your dependence on solo and small practices, help to build stronger groups
Consider establishing a Division that is focused on physician relations
Evaluate the hospital and medical group contracts to maximize compensation
Assist the physicians with training on the latest coding and billing techniques
Support medical groups that support PCPs
Consider hospital-based community clinics or foundation models
Sponsor adoption of new technology to better manage care and integrate the community services you provide

DON'Ts
Don't pay for goodwill
Don't give blanket salary guarantees
Don't try to control or manage practices, help groups to manage themselves
Don't try to change solo physicians into group practice physicians.

Walter Kopp is the President of Medical Management Services, a healthcare consulting group in San Anselmo, California. He has worked extensively with many medical groups and health systems to anticipate the coming changes in our healthcare system and to help physicians and hospitals to deal with these changes. He can be reached at or call: (415) 457-5023