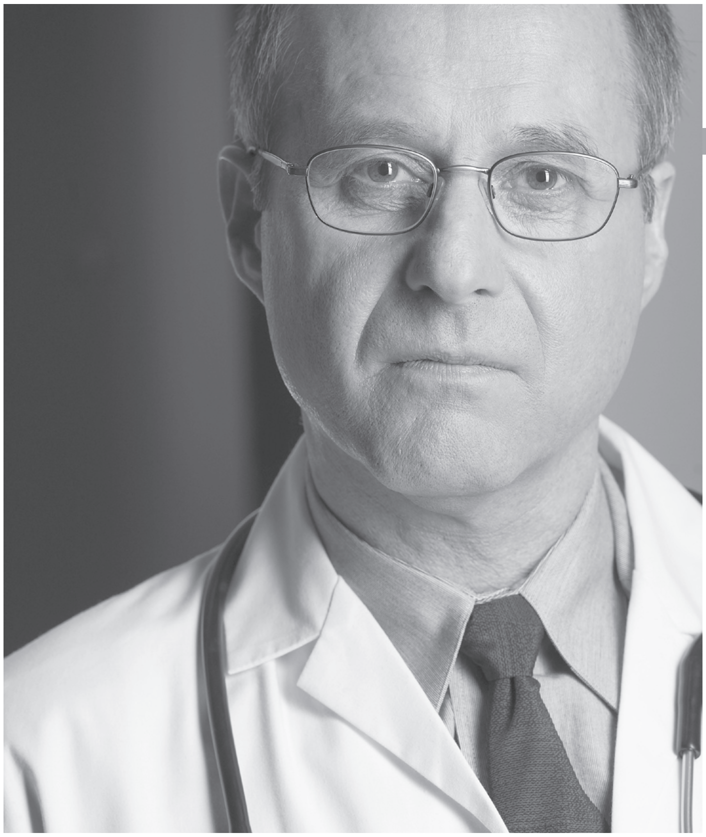

Is the Sun Setting on the Private Practice of Medicine in Maryland?

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The U.S. health care system is at a crossroads. Health insurance reform, runaway health care costs, uneven quality and medical errors, unprecedented investments in health information technology, and rapidly changing demographics are challenging the "health care norm." These forces threaten all actors in the system, but in particular they threaten physicians. There is some question, even concern, that the legacy of the strong, independent physician practice may be in jeopardy. In Maryland, this fear is exacerbated by a mix of environmental conditions and a regulatory system that subsidizes hospital inefficiency at the expense of physicians' economic viability.

For these and a number of reasons to be explored, there is a risk that we may be witnessing the diminution of the independent private practice in our nation; these signals are palpable in Maryland. Physicians have to be ready for the possible permutations of their future path, and must identify how they can prepare for that daunting, uncertain future. We will present this case by first providing an overview of the current climate for physicians in Maryland, followed by an assessment of the two significant legislative actions of the past two years (and really the last four decades)–namely the passage of the American Recovery and Reinvestment Act in 2009 and the Patient Protection and Accountable Care Act (PPCA) of 2010. We will close with our assessment of how independent physicians can ready themselves for this impending sea change.

Economic Troubles

Few would debate characterizing the recent economy as tumultuous; many have used much stronger language. Record unemployment and downright depressing economic conditions have been driven by the collapse of banks, precipitous drops in the stock market, and the shuttering of small and large corporations alike. Bucking overall economic trends, U.S. health care expenditures, representing $2.3 trillion in 2008 (upwards of 16 percent of US Gross Domestic Product) continued to (far) outpace economic growth. Growth in health care spending in 2008, however, did grow at its slowest rate in years. Consumers viewed elective procedures as truly elective, access to credit for hospitals and physicians faltered, and health care employment, typically a major driver of workforce growth, slowed dramatically.

Maryland's economy, while certainly not immune to these forces, enjoys some level of economic insulation as a result of federal government activity, military spending, and the strong presence of health care industry. While unemployment in Maryland remains at record highs, the unemployment rate is approximately two points lower than national averages, and Maryland's economy is rebounding faster than other states. From September 2009 to September 2010, Maryland's non-farm employment grew nine percent, netting some 24,000 jobs-with a number of new jobs occurring in health care. During the same period, US non-farm employment only grew .3 percent, a paltry number in comparison to Maryland's growth.

Maryland's Practice Environment

Health care spending is a significant contributor to Maryland's employment and economy. Hospitals and physician offices represent some 6 percent of Maryland's workforce. Further, physician offices represent some 37 percent of all health care establishments and account for approximately 16 percent of all health care employment. A 2008 economic impact report revealed that private physician offices in Maryland generate over $8 billion of

Exhibit I-1: Selected Positions and Hourly Wages					
	RN	**LPN**	**Medical Assistant**	**Receptionist**	**Medical Records & HIT**
National	$32.35	$17.68	$13.69	$12.71	$14.33
Maryland	***$36.70***	***$23.71***	***$15.18***	***$13.40***	***$18.91***
Delaware	$34.02	$22.70	$14.69	$11.93	$15.31
Virginia	$30.42	$18.25	$14.34	$12.58	$16.61
Pennsylvania	$30.58	$19.85	$13.78	$12.04	$15.46

Source: Bureau of Labor Statistics: May, 2009

economic activity.[1] Eight billion dollars is significant, but perhaps not surprising when one considers that physicians actually command and control a great deal of spending through their role in ordering diagnostic tests and ancillary services, referral activity, admission activity to both acute and post-acute facilities, and utilization of drugs.

While physicians drive a significant share of economic activity in Maryland, the business of practicing medicine in Maryland is changing, growing increasingly challenging. One reality for physicians is that the expense side of the ledger continues to increase while revenues are flattening or decreasing. Factors ranging from office space, labor expenses, cost of living, and Maryland's tax structure threaten practice viability. Consider the following:

Office Space: Hanging out the proverbial shingle is expensive in Maryland. Class A and Class B physician space is approximately 15-25 percent greater than bordering states such as Virginia, Delaware, and Pennsylvania.

Non-physician labor costs: The Medical Group Management Association's (MGMA) revenue and cost data indicate that non-physician labor and operating costs account for roughly 50 percent of total medical revenue. Exhibit I-1 demonstrates that Maryland eclipses its neighbors for clinical and administrative support. An area of potential concern is the significantly higher wages for medical records and health information technology (HIT) talent. As the health care ecosystem transforms from a paper system to a digital platform, the health information workforce, already receiving premium wages, will continue to demand higher wages.

Cost of Living: In the second quarter of 2010, Maryland's cost of living ranked as the seventh highest in the country. At the heart of the high cost of living is housing, and Maryland's cost of living index is the 3rd highest in the country. When physicians make a decision about where to practice, many factors are at play: family, economic factors, geographic surroundings, schools, reimbursement, and malpractice climate. While Maryland is attractive in many ways, it remains as one of the most expensive places to live.

Tax Impact: The Tax Foundation presents an annual "State Business Climate Tax Climate Index" that compares states' business climates. The report studies the impact of five tax measures: individual income tax, sales tax, corporate tax, property tax, and unemployment insurance. Each of these areas is assigned a different weight: individual income tax is weighted the greatest, followed, in order, by sales tax, corporate tax, property tax, and unemployment insurance. For the 2011 Tax Climate Index, which is inclusive of all five tax indices, Maryland ranked 44th, one of the 10 worst states for tax climate. Worse yet, Maryland fell 20 spots from its 2008 ranking of 24th. Exhibit I-2 highlights the results of index for Maryland and its regional neighbors.

Exhibit I-2 State Business Climate Tax Index			
State	**Overall Rank**	**Corporate Tax**	**Individual Income Tax**
Delaware	8	49	34
Virginia	12	4	17
Maryland	***44***	***14***	***49***
Pennsylvania	26	38	14

Source: The Tax Foundation. FY 2011

Health Care Reform

Regardless of whether the recent mid-term elections have the effect of slowing the ultimate implementation of the Patient Protection and Affordable Care Act (PPACA), it is clear that an "appetite for reform" will drastically alter the landscape for physicians. The pressures on health care practitioners are structural and endemic and reform-mindedness and renewed market pressures will drive:

- Increased coverage for individuals previously uninsured, manifested largely through tremendous growth in Medicaid enrollment;
- A focus on quality and a movement toward pay-for-outcomes payment models;
- A steep, uncertain, and undoubtedly expensive "forced march" towards an electronic health care ecosystem;

- Increased scrutiny around and focus on assimilating evidenced-based clinical standards in an effort to reduce what David Cutler from Harvard estimates is $700 billion of waste in the US health care system;
- A movement away from fee-for-service payment schema toward "back to the future" payment models–percentage of premium, risk-bearing contracts, bundled payments, and global budgeting schemes;
- Increasing pressure on provider payments as already subsidized public payers grow at the expense of commercial payers; and
- A more engaged patient; a new generation of "technology-unconscious" consumers that will demand greater access to their health information through health information exchanges, patient portals, secure email communication, social media etc. These tools will certainly change the traditional patient-physician "office" touch-point.

The "Real Delivery System Reform"

There is growing consensus that the lack of clinical information transparency – clinical information that is either in paper form or siloed away in disconnected software systems – is a key contributor to the problems before us. To help remedy this, the federal government is making unprecedented investments to modernize US health information technology. Under the American Recovery and Reinvestment Act's (ARRA) Health Information Technology for Economic and Clinical Health (HITECH), providers and states are receiving billions of dollars in economic incentives and grants to modernize health IT infrastructure. Specifically, physicians and other ambulatory providers will strive to qualify for Medicare or Medicaid incentives for achieving meaningful use, demonstrating the value of using certified electronic health records systems

With HITECH's passage on February 17, 2009, the federal government embarked on an approach to facilitate the adoption of health information technology that may ultimately do more to reform the health care system then the signature health reform legislation passed a little more than a year later. HITECH will have a profound impact on physicians, especially those in private practice. Ultimate achievement of meaningful use will require many physicians to make significant new investments in information technology, or in some cases investments to upgrade legacy technology that requires a refresh. Beyond tangible investments, meaningful use will require the substantive redesign of the way medical practices are structured and operated, forcing changes to work flows that providers and staff have taken for granted for years, and requiring new trading relationships with a variety of third parties. The journey toward meaningful use will require practices all across the U.S. to collect certain data, in a structured, standard way to facilitate the reporting of a variety of business process and clinical quality measures. The ultimate goal is to build a true health information ecosystem, ensuring that the right information, semantically and contextually appropriate, is available to the right provider at the right time. This paradigm holds the promise of truly ubiquitous, on-demand access to health information.

Consolidation In Your Future?

The convergence of these factors lends to a conclusion that there will be tremendous consolidation in the U.S. health care delivery system, especially among physicians, other ambulatory providers, and hospitals. Relative to hospital consolidations, a harbinger of overall concentration of delivery resources, merger and acquisition activity in the second quarter of 2010 saw a 26 percent increase over the same period of 2009.[2] Clearly, health reform has spurred the industry to consider acquiring, merging, and partnering to achieve economies of scale, drive efficiencies, and ultimately to grow scale to empower their negotiating position with payers and purchasers.

Many industry observers expect a very similar and maybe even more pronounced consolidation wave in the physician space. The physician business in the U.S. is a very fragmented sector; while there are some 900,000 physicians in America, 75 percent of them practice in small groups of less than eight physicians. These practices face the double-whammy of being both a small health care entity, with all of the complexity that entails, and also a small business – prone to all of the usual challenges of small business such as the disproportionately higher burden of health insurance costs, over-reliance on a few, key employees, excessive exposure to regulation, etc. These small enterprises, based on data presented herein, face a future of flat revenue, ever-increasing costs, a heightened regulatory burden and a requirement to purchase, deploy and operate technology at a very sophisticated, integrated level. Further, new physicians entering the industry are doing so with new-found expectations of financial flexibility, predictable work schedules and manageable lifestyles–not the potential risk-bearing partners incumbent physician-entrepreneurs are seeking to grow their business and minimize their enterprise risk.

One likely participant in the consolidation of medical practices will be hospitals and health systems that wish to employ physicians, and still others that feel forced to employ physicians because of defensive fears. Either way, hospital employment of physicians, while different than during the physician-feeding frenzy of the 1990s, still does not seem like a concise fit–physicians and hospitals have a natural distrust of each other, and concentration of delivery assets by hospitals still causes purchasers a lot of heartburn. Therefore, this trend may not be permanent, but it is becoming pervasive It remains to be seen whether hospitals will learn the hard lessons of the '90s, namely that physicians should be managing physicians and that people respond to incentives.

The Road Forward

So, how should physicians in private practice respond to this uncertain, risky environment? Despite the barriers and obstacles, there remain significant opportunities for physician-led and physician–owned enterprises. Physician entrepreneurs are critical to driving improvements in our health care system. They wield an enormous amount of power and control a large percentage of ultimate health care expenditures through orders and referrals. Further, entrepreneurial physicians are closer to the patients and have built service access that is sensitive to the needs of the market they serve.

The era we are moving into calls for a new approach to the physician-directed enterprise (PDE). PDEs can build expertise, talent, and leadership in a number of areas that will differentiate them moving forward.

The current system ain't getting it done. First, PDEs have to "face the brutal facts" to borrow from Jim Collins' "Good To Great experience." The brutal facts are that the health status of patients is not where it needs to be. The health care system is overly expensive, wasteful, unsafe, inefficient… you get the story. So Step 1 is facing reality.

Population Health is King. There needs to be broad recognition that the current payment system cannot sustain itself – Fee For Service medicine creates perverse incentives, misaligns incentives, and mal-distributes resources. Slowly but surely, purchasers will move to systems that pay for outcomes. This implication, in and of itself, drives complexity because the entire structure of most ambulatory medical enterprises is predicated on fee-for-production. Physicians should view health care through the lens of a global budget that has to be reasonably constrained and trade-offs entertained. Also, participants have to migrate from the world of medical care–where the delivery of services is the output of the system–to a system of health care in which health status improvement will be rewarded.

Information Technology is the Key Enabler. If one buys into the first two points, then this becomes a no-brainer. For those that do not, the future of connected information superhighway in health care will be here before you know it. In fact, access to government incentives in years 2013-2019 will likely rest on providers' ability to share information freely, openly and interoperably–both *inter*-organizationally and *intra*-organizationally. It is very conceivable than one could wake up in 2015 and find that the entire practice of medicine, short of direct hands-on care to patients, is managed by an interconnected digital ecosystem of other systems – a system of systems. If you wake that day and cannot connect, you lose.

Safety in Numbers…Maybe?

One knee-jerk response to the daunting market conditions may be that bigger is better, and that may be an appropriate response. In markets all across the country, purchasers are lining up to make fewer decisions about network providers, not more – in other words, health plans will choose to work with fewer, more-qualified, higher quality, value-oriented physicians and physician organizations. The movement to "narrow networks" will not be just a California phenomenon, but will pervade prospective relationships all across the country. In an era where federal reform and many states will require minimum medical loss ratios, health plans will look to "lock-in" the cost of care. Against the backdrop of multiple population health aggregation strategies like patient-centered medical homes and accountable care organizations, winning physicians will have to be integrated, in some way, with larger groups of high-quality providers. These groups will have to prioritize building population-health competencies around a distributed electronic record, a digital supply chain, advanced care management systems, and even applications of consumer-directed health strategies such as easy access walk-in centers.

All of this being said, consolidation for consolidation's sake is not a viable strategy. We are moving to a world which will prosecute "guilt by association," and there will always be room for centers of excellence or concentrated clinical excellence in select clinical categories. So, each physician and practice needs to make the commitment to assess their particular situation and plan ahead.

One thing is certain. The healthcare environment facing physicians is daunting, both from a national and local perspective. Private physicians play a critical role in the delivery system, but maintaining independence will become increasingly more challenging. Despite the challenges, private physicians who take proactive steps to innovate their business and clinical operations will prevail.

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