MGMA

Medical Group Management Association

February 2005

Connexion™

Recognizing the primary care 'nose dive'

By Craig D. Pederson

While independent primary care practices are an endangered species in some regions of the country, in other areas small- to medium-sized groups thrive. The futures of those practices will depend on early recognition of environmental threats. Failure to recognize warning signs can put a group into an economic nose dive from which it cannot recover, limiting its options and threatening its independence.

Independent groups share many traits

How do some groups retain their autonomy while others abandon private practice for hospital employment models or larger, multispecialty groups? Explanations vary, but many successful autonomous groups have commonalities.

Payer environments, local culture — Physician reimbursement can differ significantly from one region of the country to another. Groups fortunate enough to practice where fees are higher have significantly better chances of maintaining competitive physician incomes.

Highly productive physicians — An independent physician group with physicians who produce above the norm can significantly lower its overhead per unit of work produced. Shareholders understand the work required to build and maintain a thriving practice. They also understand the relationship between production and overhead, and the exponential increase in practice profitability at the higher tiers of production, when fixed overhead expenses are covered and a higher percentage of revenue goes directly to physician compensation.

Strong practice leadership — Strong leadership, both at the physician and administrative levels, can keep practices operating at maximum efficiency. Leadership is especially critical for small groups that lack the data that medium- or large-sized groups take for granted.

While the above factors helped many physicians and practices resist the move to employment models during the primary care arms race of the '90s, their efficiency, thin operating margins and small size leave them vulnerable to environmental changes. Independent primary care groups tend to subscribe to an "if it isn't broke, don't fix it" credo; leaders must stay vigilant to keep them from a position that requires a radical new practice model — that is, hospital acquisition or employment.

Early — and sometimes not so early — warning signs of a nose dive

100 percent "bottom-line" focus — Is your primary care practice attempting to maintain physician income levels by reducing overhead expenses vs. increasing income? This strategy can work in the short term, but over the long haul it can keep groups in sub-par practice space, with inadequate staff and without the technology to operate effectively.

Too frequently, physicians and/or management teams of independent primary care practices delay key investments to the point of crisis. Failure to buy appropriate information technology leads to system crashes and lost data. If a group relies solely on reducing practice overhead to maintain physician income, it risks overlooking the need to make long-term technology investments.

Overdependence on a single payer — One local payer may support the existence of independent primary care groups in the marketplace. When several payers exist, they may reimburse primary care at too low a

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level to sustain independent practices. This forces independent physicians to move to employment models subsidized by a hospital or health system, or go to larger, multispecialty group practices that have enough physicians to make investments that sustain growth.

Inability to retain new physician practices — The small size of many practices makes recruiting new physicians difficult without salary guarantees from local hospitals. Even so, when these guarantees end after one or two years, primary care groups may have to subsidize physicians' income or let them suffer the consequences if their practices aren't full. This can lead to a revolving-door situation as new physicians quickly enter and exit the practice. The group simply cannot support additional growth without long-term, outside assistance.

High production levels/average compensation — Independent physician groups with high production and only average compensation may also risk loss of autonomy. Yet they are also the least likely to identify and rectify potential problems.

Case study

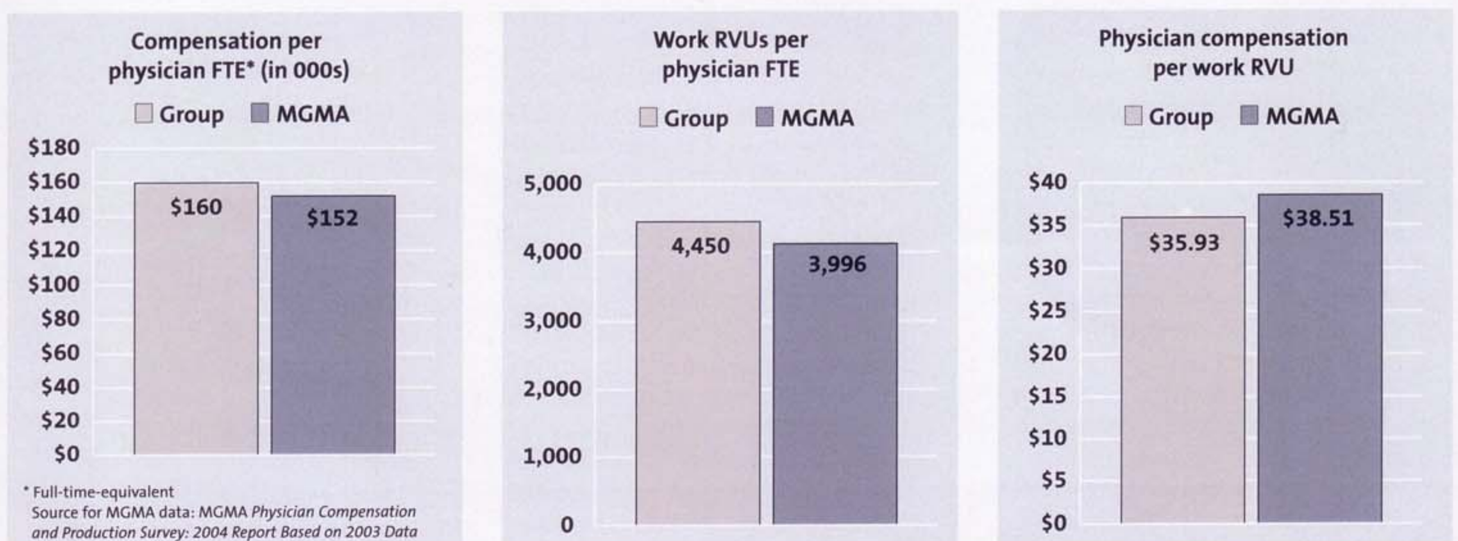
The following case study illustrates the issue. A 20-physician independent primary care group earns average compensation per full-time-equivalent (FTE) physician that is 5.3 percent above the Medical Group Management Association (MGMA) median (see first graph below). The group's compensation figure includes income earned from both on-site ancillary services and a joint venture with the hospital. Physician production, on average, is 11.4 percent above the MGMA median — for family practitioners without obstetrics (see second graph below).

Taken separately, these figures could be viewed positively: income levels above the norm and hard-working primary care physicians with full practices. But when analyzed together, they suggest that the physicians work harder than the norm per dollar of income earned. That conclusion is confirmed in the third graph below, which demonstrates that physician income per work relative value unit (RVU) is 6.7 percent below the MGMA median.

The case study group has hardworking physicians, strong management and well-developed sources of additional ancillary income. Yet it barely keeps up with market compensation rates. If the group's position continues to worsen, it may struggle to attract and retain quality physicians.

Acknowledging problems promptly permits development of strategies to address market-specific issues. Potential solutions may include affiliations or mergers with other independent groups, development of joint-venture opportunities or employment by a hospital/health system model. Time is less of a factor when evaluating the acceptability of an existing employment model for an individual physician.

Therefore, groups wanting to secure their independence must recognize threats early to maximize their options and reduce the chance that they will be forced into less-desirable employment strategies.



* Full-time-equivalent
Source for MGMA data: MGMA *Physician Compensation and Production Survey: 2004 Report Based on 2003 Data*

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