To augment knowledge gathered from the literature review presented in part I of this report, we conducted interviews with various stakeholders. The goal was to identify opportunities and challenges for solo and small group physician practices. Stakeholders included physicians, executives from Medi-Cal managed care plans, IPA executives, and leadership members from medical advocacy groups. Representatives from HI-TECHLA and an academic researcher familiar with solo and small group physician practices were also interviewed. The diversity of stakeholders interviewed allowed for differing perspectives to fully describe the issues impacting solo and small group physicians.

Stakeholders provided insight into several key factors impacting private physicians. Six major themes identified include:

- **Shift in Preferred Practice Models**
  More physicians, especially recent graduates, are joining larger group practices. This creates a gap in coverage for patients living in areas where physicians are retiring. There is a special need for solo and small group physicians in rural and underserved communities.

- **Low Medi-Cal Reimbursement**
  Physicians receive low reimbursement amounts from Medi-Cal. These amounts are significantly less than those received from commercial payors and by FQHCs. The limited amount of funds from Medi-Cal reimbursements restricts services that can improve the quality of healthcare and makes it difficult to support EMR implementation.

- **Electronic Medical Records**
  An EMR system is an important component to advancing solo and small group physician practices. However, barriers persist, including locating funds for implementation, financial loss after implementation, and ongoing training needs to ensure full functionality and efficiency from the system.

- **Independent Physician Associations**
  California’s Independent Physician Associations (IPAs) have varying degrees of efficiencies, with low-performing ones adversely impacting the clinical practices affiliated with them.

- **High Administrative Demands**
  Physician practices have substantial administrative demands. Much of the information that various health plans and IPAs request is duplicative, yet slightly different, and there is no standardized, streamlined way to request and submit this information.

- **Partnering with other Entities**
  The general consensus of stakeholders is that solo and small group practitioners will need to partner with larger entities to remain operational. Partnerships will provide necessary capital for practices to invest in EMR systems, additional staff and overhead efficiencies.

Addressing these challenges requires a combination of community advocacy and legislative action to implement. Although many of the identified themes are not new concepts, the changing health care system makes finding answers even more vital. Without adequate attention to this population of providers, the solo and small group private practice model may cease to exist. California must continue to support its existing provider workforce; especially private practices that underserved communities rely on.

This report consists of three parts that identify and discuss challenges that limit solo and small group practices’ viability as provider models in the current health care landscape. In Part I of this report, we presented an overview of California’s physician practice landscape. This section, part II, covers findings from stakeholder interviews, and reveals the challenges of solo and small group physician practices. Part III presents ITUP’s recommendations for multilevel approaches to sustain and improve the solo and small group practice model.
Stakeholder Feedback on the Evolution of the Private Practice Model

Shift in Preferred Practice Models

Stakeholders reported a growing number of physicians joining larger practices versus solo and small group practices. Based on membership demographics, Medi-Cal plans and stakeholders from medical associations have observed a decreasing number of solo and small group physicians. Lack of economic stability and generational differences were stated as the main causes for this trend. This observation is supported by the literature that shows decreased interest in solo practices by new physicians due to financial instability and its poor work-life balance. However, stakeholders stated that these practices still represent a sizable population of Medi-Cal providers. In interviews with L.A. Care and the Inland Empire Health Plan (IEHP), Medi-Cal health plans in Los Angeles and the Inland Empire, respectively, L.A. Care stated that 40–50% of their primary care providers are solo and small group physicians, while 60% of IEHP’s physician members practice in these settings.

Stakeholders also identified the scarcity of new physicians eager to invest and practice in rural, underserved settings. This is problematic because there will be gaps in healthcare access when older physicians retire in these areas. Many stakeholders suggested that physicians should begin creating succession plans so communities are not left without these critical access points. Succession plans map out ways to recruit new physicians. For example, one provider described his membership in the National Rural Health Association and how he utilizes their recruiting website to advertise his practice. Other physicians, not necessarily in rural areas, have established relationships with local medical schools and residency programs to recruit physicians. Physician recruitment might prove difficult, as larger practices are able to offer competitive hiring packages that solo physicians cannot offer. Yet, if physicians create a mission-oriented practice that resonates with recruits, solo and small group private practices may gain a competitive edge. Another likely resource is training programs that serve as workforce pipelines for small and solo practices. University pipeline training programs that encourage and assist high-school students in their journey to return as “homegrown” primary care physicians can also support recruitment efforts of physicians invested in these areas. Additionally, organized medical associations are aware of challenges to solo and small group physician practices, rural and otherwise, and advocate on their behalf. Ethnically focused medical groups especially concentrate on this trend and associated issues, as their membership base disproportionately represents these practices.

Low Medi-Cal Reimbursement

The biggest issue for solo and small group practices is the low Medi-Cal reimbursement rates. California is ranked 47 out of 50 in Medicaid reimbursement levels. Stakeholders feel strongly that the only way to ensure the viability of solo and small group practices is to increase reimbursement amounts. Solo and small physician practices stated that they must maintain a diverse payer mix and accept all types of insurance in order to make up losses from Medi-Cal reimbursements. A higher reimbursement amount will provide more economic stability for these practices.

Although most primary care physicians (69%) see Medi-Cal patients in their practice, the overall ratio for primary care physicians participating in the program is approximately 35 to 49 full-time equivalent (FTE) practitioners per 100,000 enrollees. This ratio is significantly below the national recommendation of 60

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to 80 FTEs per 100,000 enrollees. A higher reimbursement would increase provider participation to meet the access needs of the expanded Medi-Cal population.

Stakeholders also stated that the short-lived Medi-Cal enhanced payment rates for primary care physicians were not effective in increasing the number of physicians accepting Medi-Cal patients. Payments from Medi-Cal were retroactive, which did not immediately support physicians when they began caring for more Medi-Cal patients. Furthermore, federal guidance was either delayed or without enough clarity to properly guide Managed Care Organizations (MCOs) on the implementation of payment increases. The payment bump was scheduled to go into effect January 1, 2013. Yet, the federal Department of Health and Human Services (HHS) did not offer formal guidance on eligible providers until November 1, 2012. Also, because each state's Medicaid managed care program is structured differently, the federal government was only able to offer broad guidance. For states like Oklahoma that administer their own managed care program, it may have been easier to implement this provision because contract negotiations with external contractors were not necessary. But for California, which is composed of multiple MCOs, each health plan negotiates its contracts with the state. This lack of clarity led to providers receiving different increases from each plan as a result of differences in distribution practices. A physician noted that L.A. Care provided enhanced payments to medical groups to distribute to providers, while Anthem Blue Cross directly paid their providers. Most upsetting to physicians is one health plan's refusal to pay rate increases to physicians without board certification in a primary care specialty. For example, if a physician is board-certified in obstetrics and gynecology (OB/GYN), and also practices family medicine but is not board certified in that discipline, they are required to attest that at least 60% of their services fall under primary care. Only physicians board-certified in a family medicine discipline were compensated without this additional hurdle.

Unfortunately, California has decided not to continue with this higher reimbursement rate, citing budgetary constraints. In general, stakeholders believe California needs a long-term increase in Medi-Cal reimbursements to incentivize more private primary care physicians to serve Medi-Cal beneficiaries.

In comparison to FQHCs, solo and small physician practices are unable to attain certain resources, such as community health workers or EMR systems due to the lack of funds from Medi-Cal reimbursements. Stakeholders expressed their frustration with being required to meet the same quality metrics as FQHCs, but with less money to do so, as FQHCs have access to federal grants and cost-based reimbursements. As we mentioned in part I, FQHCs receive additional funds because of their obligation to practice in underserved areas and see all patients despite their ability to pay. Independent physician practices do not have this same obligation. But in instances where independent practices are serving uninsured individuals, to support the goal of health for all, assistance from an outside source is needed to supplement narrow profit margins.

**Electronic Medical Records**

Stakeholders agree that EMR systems have many benefits and will be a necessity in the future to validate claims of quality care provided by solo and small group physicians. However, barriers persist before and after implementation of this technology. Cited barriers are the cost of the EMR system, which includes office infrastructure, equipment, and software; initial loss in productivity, ranging from at least three

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5 Ibid.
6 The ACA required Medi-Cal payments to be increased to the equivalent of Medicare payments for both FFS and managed care programs. Payments were applied retroactively for services provided on or after January 1, 2013.
8 Ibid
9 Ibid
10 Ibid
11 Governor Brown’s May Revision for the State Budget cites a new estimated increase of $6.7 billion in General Fund revenues. However, these funds are earmarked for other programs, and under the Governor’s proposal, the State will not be taking on any commitments beyond those proposed.
months to a year; and limited access to training or funds for personnel to reap the full functionality of the EMR systems. For private practices, especially those with one to two physicians, loss in productivity weighs particularly heavy. Practices must reduce their patient schedule as they familiarize themselves with their new EMR system. This sizeable decrease leads to a reduction in cash flow. With tight profit margins, initial costs may put practices in jeopardy if no prior savings or plan is in place. Thus, the high cost of EMRs coupled with low capitated rates from managed care plans presents a significant issue for physicians.

Federal grants distributed to solo and small group practitioners have had a positive impact for EMR implementation. A number of solo practices in Los Angeles County were able to successfully choose and implement an EMR system with the assistance of HITEC-LA, a Regional Extension Center (REC) in Southern California. HITEC-LA was exceptionally successful in meeting its aim to provide EMR resources to solo and small group practitioners due to support, both financial and technical, from L.A. Care. L.A. Care provided human resources capabilities, office space for the HITEC-LA team, and any needed capital. Furthermore, L.A. Care contributed incentives to its providers, in addition to federal incentives available to practices who met meaningful use 1 criteria. In Riverside and San Bernardino counties a Local Extension Center (LEC) has been established. The LEC is a non-profit organization formed by two local medical societies and IEHP. It is known as the Inland Empire EHR Resource Center (IEEHRRC). The Inland Empire has also set up its own interconnected Health Information Exchange (HIE) in which a number of different organizations, including hospitals, physician groups, clinics and other organizations can exchange patient health information. The HIE is the largest in Southern California and aims to increase timely care coordination and quality of care for patients in the Inland Empire. Many other counties throughout the state are struggling with interconnectivity between EMR systems, and implementation of a HIE might be a way to work around this issue. Additional federal funds for the REC and LEC programs have not yet been approved.

The biggest issue with EMR implementation for solo and small group practitioners is the loss of revenue due to the time required to gain experience with the system. Stakeholders cite a 60% decrease in patient volume. Even after implementation, using the EMR system needs to be integrated into new workflows, which can take multiple adjustments and additional time to perfect. On average, we found that physicians do not have the funds to invest in training or hire personnel who can fully utilize all aspects of the EMR system to make a more efficient practice.

County differences exist in the number of practices achieving meaningful use criteria. For example, in Los Angeles County, as of March 2014, more than 2,500 eligible providers have self-attested to completing meaningful use 1 with the assistance of HITEC-LA. Yet, in the Inland Empire, only a handful of providers have reached meaningful use 1. For early implementers, demonstration for achieving meaningful use 2 started in 2014. Since federal funds were only rewarded for physicians to reach meaningful use 1, the onerous task of reaching meaningful use 2 is solely placed on the solo practice with no guidance on how to reach this next, more sophisticated stage.

As designated by the Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology, Meaningful Use is a standard set of objectives and measurements that providers must meet if they participate in the Medicare and Medicaid EHR incentive program. Providers must attest that they are meaningfully utilizing EHR technology to improve quality of care and health outcomes for patients. There are three stages of meaningful use. Each stage has different criteria that build upon the last, becoming more complex and integrated.

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12 A Regional Extension Center is a non-profit organization that assists health care providers to select and implement EHR systems in their practice. It was initiated and funded by the HITECH Act.
13 There are four Regional Extension Centers in California. HITECH-LA, a branch of L.A. Care serves the Los Angeles region. COREC serves Orange County and is supported by CalOptima, the Medi-Cal plan in Orange County. CalHIPSO serves the remaining 56 counties in the state. Lastly, there is the California Rural Indian Health Board, REC-CA.
14 In order to reach meaningful use 1, small practices must accomplish 18 metrics.
15 Due to the fact that CalHIPSO is serving 56 counties, Local Extension Centers (LEC) were created to delegate the functions of a REC to the counties. CalHIPSO contracts with ten LECs around the state.
16 Meaningful use 2 is a higher tier of EMR capability in which providers must accomplish and report on 20 objectives.
There is currently no data on the number of practices that have reached meaningful use 2 in the regions interviewed for this report.

Despite the large barriers, efficiency from the EMR is the ultimate payoff that physicians cited after utilizing EMR systems for over three years. What’s more, physicians noted that as there is a move towards managing population health, EMRs will be critical in this new paradigm of health management.

**Independent Physician Associations**

Stakeholders discussed two tiers of issues that they experienced with IPAs; 1) issues between the solo and small group physician practices and IPAs, and 2) issues between health plans and IPAs. The issues between the health plans and the IPAs also trickle down to the solo and small group physician practices.

**Solo and Small Group Physician Practices and IPAs**

Interviewees cited differences among IPA performance levels. The difference in performance levels between IPAs can be attributed to their payers, with a majority of the poorly performing IPAs contracted with Medi-Cal health plans. Due to the fact that Medi-Cal reimbursement is low, IPAs struggle to perform administrative tasks, as well as pay for clinical services within this capitated environment. Administrative functions include conducting prior authorization, financial management, and education and training of physicians. For example, solo practitioners see long delays in receiving reimbursements from IPAs, sometimes up to 90 days, due to lost paperwork and provider disputes concerning denied clinical procedures. These lengthy payment gaps are distressing for solo and small group practices that may have a limited payer mix.

It is evident that the cited criteria of high-performing IPAs, from the physician perspective, include proper management of claims and consulting and support services to physicians. These characteristics, which are credited to IPAs such as Hill Physicians Medical Group, Brown and Toland, and HealthCare Partners, are missing in our stakeholders’ experiences. The IPAs discussed in the interviews are struggling to fully take on all responsibilities from Medi-Cal health plans due to limited financial resources.

IPAs that contract their administrative functions with management services organizations (MSOs) are said to have higher functioning claims processing. MSOs are organizations that provide management and administrative support services. Stakeholders stated that reimbursements are promptly deposited, usually within 30 days, from IPAs with an MSO. Prompt payments were positively associated with how well physicians thought IPAs were performing.

In addition, one of the most important drivers for joining an IPA is their perceived negotiation power with health plans. However, stakeholders contradicted the idea that participating in an IPA increased their reimbursement rates. Many physician stakeholders stated that IPAs offered capitation rates with no opportunity to negotiate. If a provider is displeased with an offered rate, the IPA does not reconsider their offer. The IPA moves on to another provider, offering them the same rate. This action is specific to a region that has many primary care physicians. Concrete data to support these observations are not publicly available and thus could not be confirmed through other sources.

**Health Plans and IPAs**

It is also the responsibility of the IPAs to educate and provide training to their physician members. There was contradictory feedback regarding the success of such trainings. For example, some physicians stated that monthly meetings were held by their IPAs, whereas other physicians stated that their IPAs did not hold such meetings or that attendance was not a requirement. Although health plans verify that trainings occur through an audit process, it is unclear if health plans verify or ensure the effectiveness of these trainings through established metrics. It is also unclear if the poorer quality providers receive more attention and resources from IPAs to help increase quality.

**Variation in Direct Contracting with Health Plans**

The option for private practices to directly contract with health plans differs between counties. In Los Angeles County, this option is no longer available. In the past, Care 1st health plan directly contracted with private physicians, but as a cost-saving mechanism, no longer offers this option and exclusively contracts with IPAs.

In contrast, IEHP offers direct contracting with private practices, in addition to contracting with IPAs in the area. Approximately 49% (592 PCP providers) of IEHP’s providers are under direct contract with the health plan, essentially making up the largest medical group in the county. The remaining 51% of providers are contracted with one or more of the region’s twelve Medi-Cal IPAs and ten Medicare IPAs. IEHP implemented this direct contracting model to ensure better oversight of the quality of their providers. In this model, IEHP is able to provide the needed resources, assistance, and quality improvement services to these providers. As a result, there is improvement in plan “risk” as many of the sickest patients and poorest performing doctors are supported directly by the health plan to improve patients’ health outcomes. Furthermore, they are slowly terminating contracts with providers at the bottom of quality ratings. IEHP will continue to provide more education and training to its providers to improve quality ratings in the region.

High administrative demands

The extent of administrative requirements for solo and small group physician practices is especially burdensome because they have limited time and do not have access to the specialized staff that larger physician groups often employ. Additionally, much of the information reporting is duplicative, coming from multiple IPAs and health plans that contract with a physician. Some physician offices also receive both capitated and FFS payments if they offer both primary and specialty care services (e.g. an OB/GYN specialist), which increase the complexity and time required to secure reimbursement. Medi-Cal coding is also notoriously more intricate, requiring multiple codes for a patient’s visit compared to commercial insurance plans, which require fewer codes. Larger groups have the resources to hire staff with expertise in coding, to maximize reimbursement amounts.

L.A. Care is aware of these high administrative demands. Currently, they are working to streamline the reporting process. They are working across all their product lines, IPAs, and with Health Net, the commercial Medi-Cal health plan in Los Angeles, to increase standardization of information and reduce redundancy of reporting. Streamlining this process will reduce the administrative workload of physicians and cut down on costly administrative staff time.

Partnering with Other Entities

The most consistent theme among stakeholders is that solo and small group practitioners need to form partnerships with larger organizations to access needed resources and remain a viable practice model. Partnerships could be established with high-performing IPAs, health plans or other physician practices. Participating in an Accountable Care Organization (ACO) is also a way to be part of a larger network. These partnerships would provide access to EMRs, training for meaningful use 2, and the ability to hire business managers and community health care workers. All of these resources will help solo and small group practitioners to improve the efficiency and quality of care delivered at their practices.

With the ACA’s emphasis on cost-containment, value based payments and coordinated, quality care, IEHP is proactively seeking creative collaborations and innovative payment structures. One idea that moves away from the IPA model is the creation of regional pods. The regional pod would include twenty-five doctors that would share risk and resources while ensuring access to consumers. This smaller pod would have the ability to focus on patient access and quality of care. IEHP is also piloting different reimbursement configurations for private physicians. Currently, they are piloting a hybrid model with three tiers of reimbursement. The three tiers of payment include a small capitated amount for care coordination, a fee-for-service tier for encounters, and reimbursements based on quality indicators and performance. The hope is that this holistic system would provide the correct incentive mechanisms for physicians to provide quality, coordinated, cost-effective care. In Northern California, related innovations have been tested. In San Francisco, the Chinese Community Health Care Association IPA is encouraging

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15 Direct contracting is no longer available in Los Angeles, except in Antelope Valley because there are no IPAs in this region.
Part II: Stakeholder Interviews

arrangements, dubbed virtual groups, between solo physician practices. In this semi-consolidated structure, physicians have separate offices, patients and medical records, but share personnel such as human resources, employees with health plan reimbursement expertise, and Information Technology staff. Each practice pays a portion for the shared personnel. In theory, these virtual groups would help to bring down overhead costs and delegate responsibilities that otherwise are performed by physicians, thus increasing the efficiency of the practice. Yet, because physicians remain organized in fragmented practice settings, there is no true care coordination or integration, which prevents quality improvements that occur in larger practices. These novel groupings and networks among solo and small group physician practices are examples of different models that if implemented appropriately, have the potential to make solo and small group practices more efficient.

Summary

Although not an exhaustive list, the six main concerns discussed by stakeholders included lack of interest from graduates to enter private practice, low Medi-Cal reimbursement, frustration with utilizing EMRs, issues with IPAs, high administrative demands, and the need to partner with other healthcare entities. As the healthcare system continues to evolve with an increasing number of insured individuals and a greater reliance on health information technology, solo and small group practice private physicians are struggling. Stakeholders must support multiple approaches to help these private physician practices to remain viable. Part III of this report provides recommendations that explore how solo and small group practices can sustain their practice model.