Solo and Small Group Physician Practices in California  
Part III: Recommendations, Limitations, and Conclusion  
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This brief concludes a three-part report that identifies and discusses challenges for solo and small group practices that limit their ability to be viable practice models in the current health care environment. Part I of this report, provided an overview of California’s physician practice landscape. In part II, findings from stakeholder interviews were covered, revealing the challenges of solo and small group physician practices. This section, part III, presents ITUP’s recommendations for multilevel approaches to support and improve the solo and small group practice model. Although these recommendations can be generalizable for all solo and small group practices, practices that do not predominately serve Medi-Cal or underserved populations may have somewhat different hardships in their practice. Thus, the following recommendations are meant specifically for private practices (with fewer than 10 physicians) that serve low-income individuals and participate in Medi-Cal managed care plans.

**Recommendations**

*Lessen work-life balance issues and financial barriers in solo and small practices to recruit more graduates to these settings.*

Physicians working in solo practice have a greater degree of flexibility in setting their schedules and have the opportunity to offer relationship-based care to their patients. Although these placements do offer physicians some autonomy, new physicians interested in this model must be mindful that true autonomy, is no longer the norm or preferred method of practice. Input and requirements from health plans—commercial and governmental, Independent Physician Associations (IPAs), and the Centers for Medicare and Medicaid are a reality. A physician’s independence is exercised through the practice’s crafted mission, vision and values, and then translated through the physician’s bedside manner and the staff’s treatment of patients. Solo physicians must be dynamic and revise the strict definition of solo practice to usher in modern health care trends.

For new graduates who are committed to this path, financial and work-life balance barriers can be addressed. In terms of finances, although employment packages from solo practices versus larger groups may not be as robust, the potential for higher compensation may come in a few years once a partnership is attained. Also, to help students with outstanding loans after graduation, the federal government offers loan forgiveness programs for physicians interested in rural, underserved locations. To address work-life balance issues, working with hospitalists is a recommendation that can lessen the demand or expectation of the physician to be available twenty-four hours, seven days a week.¹ Also, some solo and small group physicians argued that the close relationships they form with their patients enable them to educate their patients about how to appropriately access care in emergency and non-emergency situations. If physicians appropriately educate patients, after hour calls for non-emergency situations could be decreased, likely leading to reduced after work burdens. The reduction of financial and lifestyle obstacles for solo and small group physicians could potentially help draw more recent graduates into this practice setting.

*Solo and small group practitioners should create succession plans, especially in rural underserved regions.*

Succession planning among solo and small group practitioners is an important process to ensure communities are not left without access to care. Physicians in solo and small group practices can get assistance in succession planning from 1) their memberships with physician associations, like the National Rural Health Association, 2) local medical schools and 3) regional hospitals.

Physician associations should offer educational information and training opportunities in succession planning as more physicians begin to retire. Also, as mentioned by one physician stakeholder, the National Rural Health Association is a good resource for rural physicians. They provide assistance with recruitment by posting a list of available rural practices searching for successors.

¹ A hospitalist is a physician whose expertise is to care for patients being treated in the hospital.
Similarly, relationships with local medical schools can help identify recruitment prospects for a practice. Providers can form relationships with medical schools through preceptorships (mentorship), and by informally recruiting within residency programs for volunteers that wish to learn how solo and small group practices operate. Medical schools should inform students of loan forgiveness programs (e.g., National Health Service Corps (NHSC)). This way, if loan debt is seen as a deterrent to choosing a private practice setting, recent graduates are aware of available financial assistance. It is also helpful to have universities set up physician pipeline training programs. These programs can guide and assist high-school students from these regions through college and medical school with the hope of encouraging their return to their hometowns during and after residency. Such programs can help to successfully recruit and retain a solid healthcare workforce in many areas with provider shortages.

Finally, community hospitals should also pay special attention to physician demographics and retiring trends. If successors for current practices are not enlisted, practices will be forced to close. Community residents will then have fewer options to access care and likely delay receiving care until an issue becomes more acute. In this scenario, it is possible that hospital emergency rooms will be more frequently utilized as a primary source of care. Therefore, it is in the best interest of community hospitals to assist local providers with resources to find a successor, or even for the hospital itself to acquire the practice. In general, physician associations, medical schools and local hospitals can assist solo and small group physicians in identifying available resources for succession planning as they prepare for retirement.

The State should increase Medi-Cal primary care reimbursement rates.

Higher reimbursement rates will alleviate financial pressures on solo and small group practitioners and aide in providing higher quality care. However, higher reimbursement rates from the State are not a likely outcome in the near future as the Governor has cited a lack of financial resources for such action. As discussed earlier, California is not extending the ACA’s increased Medi-Cal rates for primary care that were available in 2013 and 2014. Furthermore, Medi-Cal rates have been hit with a 10% cut that took effect in 2013, except for the Medi-Cal providers eligible for the ACA’s two-year increase.2 These deep rate cuts could make it nearly impossible for practices with large Medi-Cal patient panels to survive financially. To survive, practices might be forced to decrease the number of Medi-Cal patients or close all together. Because Medi-Cal membership has increased due to the 2014 expansion, a decreasing number of Medi-Cal providers would have repercussions for access to care for program beneficiaries.

What’s more, there is a striking distinction in Medi-Cal fee-schedules between primary care and specialty care. According to the 2008 Medi-Cal fee schedule, primary care doctors received $25 for an office visit for an established patient, 66% of the national average and 39% of a Medicare charge.3 Although we paid better for office visits for new patients ($59-$72), fees still fell below the national average Medicaid fee and Medicare charge.4 This is remarkably low compared to fees received by specialist that are allowed to bill per procedure. For initial hospital care for a new or established patient, physicians received $76, 101% of the national average and 62% of a Medicare charge.5 For other specialty care, like cataract removal with lens, specialists received $1,005, 142% of the national average and 149% of Medicare fees.6 Likewise, fees for medicine and testing highlight existing disparities. For an echocardiography, physicians received $150, 105% the national average and more than a Medicare charge.7 Higher reimbursement rates for PCPs would help alleviate the current practice of scheduling patients at 15-minute intervals in order to survive financially. More time spent with patients leads to more opportunity for comprehensive care.

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3 California HealthCare Foundation. (2009). Medi-Cal physician and dentist fees: A comparison to other Medicaid programs and Medicare. Received from [http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFeeComparison.pdf](http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFeeComparison.pdf)

4 Ibid.

5 Ibid.

6 Ibid.

7 Ibid.

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Despite the fact that increased reimbursement rates is not a likely action to be taken during the next fiscal year, the State should take this time to think through ways to fund increased rates in the future.

Experiment with alternative financial models.

As discussed in part I of this report, a diverse payer mix is vital to solo physician practices, especially those that serve the underserved community. For physicians with a percentage of patients with higher incomes that chose a bronze or catastrophic plan, it may be beneficial to experiment with a hybrid model. Practicing direct primary care alongside a traditional insurance model may act as a wraparound program due to the limitations inherent in high-deductible plans. For example, if a patient schedules a visit for a physician exam, this service would be covered by their plan as a well visit. However, if this patient presents with high blood pressure, the doctor is obligated to treat accordingly, and the visit then becomes a sick visit which is not free of cost. In such instances, the preventive and primary care services offered under the direct primary care model would supplement services covered by a patients’ high deductible plan.

Opt into pay for performance (P4P) programs and focus on established metrics.

Physicians have the opportunity to increase their bottom lines through P4P programs. In some health plans, primary care physicians are automatically enrolled in these programs, in others, physicians must opt-in. It would be in the providers’ best financial interest to participate in these programs to demonstrate the high quality of care they provide and receive increased compensation accordingly. To help offset low reimbursement rates, P4P programs could provide solo and small group physician practices stronger profit margins for their successful treatment of high-cost, high-risk patients. The State may also use P4P programs as an alternative approach to increasing Medi-Cal payment rates for all primary care providers participating in the Medi-Cal program. Payments would be given only to providers that demonstrate their ability to hit targets in reducing avoidable emergency room visits, preventable hospitalizations and re-hospitalizations. This would not only incentivize providers to improve patient outcomes, but would save the State money.

Although savings can be realized, limitations exist. Multiple stakeholders must collaborate successfully to achieve what may initially be quite a narrow profit margin. If there is little money remaining at the end of the program year to distribute to providers, the incentive to participate lessens. However, stakeholders reported that as providers continue to participate in P4P programs, more gains follow. Thus, profiting from a P4P program is not a short-term goal. Providers must be patient and willing to experience some minimal gains initially in order to see more positive returns in the future.

Physicians should acknowledge and focus their time and effort on meeting these metrics and improving the value of their care to the plans. EHR technology and patient registries can assist in creating patient-specific profiles for metrics that need to be met. EHR has multiple functions intended to make practicing medicine easier, including system reminders. If a provider has a diabetic patient, their EHR system can assists by prompting providers to ask particular questions. In this way, providers are sure to perform procedures that will help meet metrics set in P4P programs. Physicians must learn to utilize the full functionality of such systems to their benefit.

Ongoing funds should be allocated to Regional Extension Centers (RECs) from the federal government to increase and improve Health Information Technology (HIT).

RECs have demonstrated their success in establishing HIT implementation and connectivity. Funding for RECs was only provided as stimulus funding from the federal Office of the National Coordinator for Health IT (ONC) and was to be discontinued as of January 1, 2014, but extensions were granted until 2015. After this date, RECs will need to be funded through other partnerships with the State, local health plans, as L.A. Care and IEHP have done, and/or medical societies. Although funding from local partnerships should be sought, it can often be unreliable. It is possible that without funds from the federal

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government, current success will be short-lived and progress will be staunted. Secure funds from the federal government would provide a more reliable financial situation for California’s RECs and maintain progress in EMR adoption, implementation, and connectivity. The extension from the ONC is a good indicator that they may be interested in continuing to fund RECs.

Moreover, RECs will be increasingly instrumental in implementing county health information exchange (HIE) systems. For example, even though many organizations now have EMRs, the different EMR systems do not connect with each other. Interfaces, which have been described as quite expensive, are required for interconnectivity. Due to the fact that solo and small group practices need to connect with many different hospitals, clinics and specialists, it will be impossible for small practices to fund all these different interfaces. However, the implementation of an HIE would require only one interface. Physicians can then access a central patient information portal. If all solo and small group physician practices had this capability it would significantly reduce costs for physicians and increase continuity of care and care coordination. RECs that are currently established could be the most convenient entity to establish HIE interconnectivity if they have the technological and financial savvy.

It is in the best interest of the federal government to continue to support RECs to reach the national goal of broad and meaningful HIT implementation.

**Health plans and IPAs must continue to standardize required information, streamline processes and drive quality.**

One of the biggest challenges for solo and small group physicians is the amount of time required to perform administrative responsibilities. A solo and small group practice typically contracts with twelve or more health plans, in addition to participating in Medicare and Medicaid plans.⁹ It is estimated that $7 billion could be saved annually from streamlined processes and a combined nine hours a day of the physicians’ and support staff’s time on administrative work.¹⁰ Streamlining processes and reducing administrative work would save money and allow more time for physicians to see patients. As a result, health plans and IPAs must continue to work together to standardize information requested from practices.

In regions where health plans exclusively contract with IPAs, the health plans must improve their oversight of IPAs. Although it is acknowledged that Medi-Cal health plans cannot easily discontinue contracts with Medi-Cal IPAs as they provide required access points, as specified by DMHC, health plans must compel IPAs to improve their practices with solo and small group physician practices. One way to do this is to make IPAs more transparent, which includes identifying metrics for quality that define high-performing IPAs. Examples of such metrics are management of medical claims, administration of clinical protocols, and the existence of consulting and supportive services through MSOs. The availability of this information would enable providers to make a more informed choice. Additionally, health plans may want to re-evaluate the current practice of solely contracting with IPAs and potentially assume direct contracting with the practices that are currently contracted with low-performing IPAs. As mentioned in part II of this report, IEHP has a large population of directly contracted practices. In their opinion, this approach has helped to improve oversight and outcomes for low-performing IPAs. Other health plans may also benefit from direct contracts.

**Solo and small group physician practices should seek out partnerships.**

In order for solo and small group practices to survive, they should establish partnerships. Partnerships can come in many sizes: a true solo physician working with another solo physician or direct contracting

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with health plans. As discussed, IEHP has experimented with a new model of physician pods that link approximately 25 practitioners to increase care coordination, performance quality, and access to local physicians. Moreover, this idea would allow physicians to pool their limited resources together.

Solo and small group practices may also require outside assistance to overcome the challenges of being a small business owner. Physicians can benefit from philanthropic organizations that supply grants for infrastructure development. This might include providing funds for the implementation of EMR systems, interconnectivity software for EMRs, and supporting ongoing maintenance for EMRs. In addition, financial assistance or pooling resources through the creation of “pods” would increase the accessibility of support from other physicians and improve care coordination efforts.

As previously mentioned, there are many benefits to partnerships. These benefits include, an expanded network, shared resources, and capital backing for quality enhancement tools like EMR systems and care coordinators. Solo and small group physicians should not underestimate the benefits of these partnerships and must do their due diligence to show prospective partners how they provide quality care to their patients and why they would be attractive for such a partnership.

**Conclusion**

Solo and small group physician practices have been a part of the nation’s healthcare system since the advent of modern medicine. They play an important role in California’s healthcare landscape in terms of patient access to care, continuity of care and serving the underserved. It is for these reasons the barriers they face must be addressed. Some recommendations to alleviate these barriers include reduction of financial and work-life balance issues, succession planning, additional financial backing from state and federal entities, participating in alternative financial models and P4P, further investment in HIT, streamlining administrative processes, and seeking partnerships. Moving forward, solo and small group physician practices cannot be forgotten in this continuously evolving healthcare landscape. Yet, in its current model, inefficiencies persist. Solo and small group practices must also evolve and align their practice styles with the current health care system to remain viable options for our new health environment and its patients.