IT'S HARD OUT THERE FOR AN INDEPENDENT PRACTICE

Independent practices are reimbursed significantly less than employed docs. Is there anything they can do to get more out of payers?

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- MAKING THE PUSH TO VALUE-BASED CARE
- THE ACA REPEAL'S IMPACT ON YOUR PRACTICE
Physicians often look at their relationship with payers through an us vs. them mindset. That’s the wrong tact to take says one doc.

BY DAVID NORRIS, MD

Payor relations — have they always been bad, or at least appeared to be bad? Or rather, could it be how we view the relationship? Will they get better or worse in 2017? I don’t know the answer to that last question, but I suspect your perception of the relationship will be key.

A growth mindset holds that everyone has potential and every situation has the potential to improve.

PERCEPTION IS KEY
When I begin coaching a client, there are some fundamental questions I ask to get an idea of how they perceive the value they bring. One of my very first questions is, “How do you see yourself?” I’ll ask follow-up questions to dig for their perception of their own worth. I want to know how they view and value the services they offer. What is the value they place on treating the patient? Sometimes it’s right; sometimes it isn’t. The goal is to get them to verbalize their value. Once you’ve established the value you offer, you’re in a much better negotiating position.

The next area I focus on is payor relations. How do you view your position in the relationship? How do you see them? How do you think they see you? I want to see what their level of need is. What is the mindset of the physician, is it a fixed or growth mindset?

A mindset is the way you think and feel about any particular person, place, or event. A fixed mindset believes the world, a person’s potential and abilities, and the pie is fixed. In doing so, that person has only one option, and this is to focus on their own needs. If you walk into an event with a fixed mindset, one that sees the situation as you versus them — for you to win, they must lose. A growth mindset holds that everyone has potential and every situation has the potential to improve. It’s not an optimistic worldview, but one that holds things have the potential to improve whether they do improve or not. A growth mindset also allows you to focus on the needs of the other party instead of your own, because you see the pie with the potential to grow. This particular way of thinking is key when it comes to any relationship.

Have you ever asked, “What do the payers need?” Have you ever wondered why payers exist? They have contracted with companies and individuals to facilitate access to healthcare providers. They sold a contract, or promise, to their customers. “We have excellent doctors that can help take care of your employees, families, or yourself.” They need those patients to be taken care of. If doctors no longer agree to see their patients, they have a challenging time keeping the promise they made to the people who bought their insurance contract. They need for a physician to see their patients. Your job as a physician is to meet that need. That’s the value you offer.

The next time you sit down with a payer, remember that you are there to help them keep their promises to their enrollees. That’s how you’re helping them. Ask questions that help frame that need in their mind. People in need are more apt to comply with requests than those who are feeling threatened and forced. Keep a growth mindset and keep in mind payers have promises they must keep to the patient as well — you’re just helping them keep those promises.

David J. Norris, MD, MBA, CPE, is an anesthesiologist at Wichita Anesthesiology Chartered in Wichita, Kan., the owner of the Center for Professional Business Development, which aids and educates physicians and other small business owners, as well as a member of the Physicians Practice Advisory Board.
Every month, there is a good chance that a practice brings in new patients. Once the visit is completed, the billing code is entered to the insurance company: 99201.

How much this practice is paid for this service is entirely dependent on the type of practice it is. If it belongs to a large healthcare system, with multiple hospitals and practices, it will average around $74 per instance of 99201. If it is an independent practice? It’s only going to be, on average, $58.40 per instance.

This disparity — and this specific example — is detailed in the 2016 Physicians Practice Fee Schedule Survey, which surveys physicians on the amount they are reimbursed from insurers for common services. It’s not just new patient visits that show the gap between what payers reimburse independent and employed practices, it’s established visits too. When it comes to CPT code 99211 for established visits, independent practices on average receive $43.10 per instance and employed practices receive $58.70 per instance.

“It’s not [a surprise] … the hospitals typically have negotiated contracts with the insurance companies. There is no hospital that’s on a standard contract.
There is no standardization in the hospital world. Each system really negotiates with insurance companies. If you’re an independent physician, you are basically signing onto these contracts at street rates,” says Susanne Madden, president and CEO of the Verden Group, a consulting firm. “Whatever the offered fee schedule is, you usually accept and sign. As a small practice, you don’t have a lot of negotiating power and leverage.”

Brennan Cantrell, commercial health insurance strategist at the American Academy of Family Physicians (AAFP), saw this discrepancy firsthand. He says he used to work for an independent practice that was bought by a hospital system. “When we were bought … our reimbursement went up 10 percent across the board. Even more for some codes.”

- Brennan Cantrell, commercial health insurance strategist

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We’re happy to bring you the results of our annual FEE SCHEDULE SURVEY — the only national examination of how much physicians are paid for common services by payers.

This 2016 survey includes respondents from every part of the country and in every specialty. Respondents told us how much they earn, on average, for the major diagnostic codes for new and established patients, as well as for some common procedure codes. Private payers won’t publicly disclose what they pay and practices are prohibited by antitrust law from sharing rate information directly with each other. Instead, you tell us how much you are being paid, then we aggregate the data and report it here — so you can compare your rates with those of your peers.
small, independent practices don’t have that kind of pull.

**EDUCATION IS THE KEY**

The good news is it’s not completely hopeless for independent practices, experts say. There are certain strategies they can employ to level the playing field. Patti Cloud-Moulds, owner of Turnaround Medical AR Recovery, a consulting firm, says a simple way independent physicians can get more bang for their buck is to be more conscientious of how they code.

“Understand your fee schedule, take a look at your codes, what’s available; did you do XYZ and you only coded for Y and Z? You have to think about that. Even if you don’t think you’ll get reimbursed [for a certain code], if you did it, code it,” says Cloud-Moulds.

Barbie Hays, AAFP’s coding and compliance strategist, says physicians should know how to “run their codes.” In other words, they should know what codes they are utilizing the most. “That’s where technology comes into play, using your EHR or
billing system to get a good representation of the codes being utilized,” she says. Using this data, notes Hays, will help physicians negotiate with payers.

Hays notes that physicians should know that 135 percent of the Medicare Fee Schedule is the “sweet spot.” While independent practices might not be able to get that rate for most codes, showing the payer which codes are used the most can help them get more than what’s being offered. That’s because this data shows payers what quality services the practice is performing most frequently and which ones makes it stand out among others in the area.

Mullins adds that physicians need to realize it’s OK to ask for more than what the payer offers.

“We go to medical school, [and] we don’t get educated [in this area]. We get educated on how to treat patients, not how to run a business. I think a lot of our physicians will go out and open their own clinic, start signing contracts, and they’ll have no idea what they are signing,” she says.

**IPAs AND OTHER STRATEGIES**

Another potential strategy for independent physicians to level the playing field with reimbursement is joining an independent physician association (IPA). IPAs can bring a practice strength in numbers, without having to sacrifice its independence, experts say.

Madden is an advocate, saying that practices who aren’t in an area with an IPA should start one. Not only is the arrangement advantageous for practices, she says, but for payers too. “As a payer, it’s easier to contract with one group rather than

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*All data averages include survey respondents who did not indicate regional location, group size, practice type, or specialty.*
1,500 individual physicians,” Madden says. She notes that for most IPAs, reimbursement rates are tied to quality metrics, which is good for the practice, payer, and patient population.

However, there are a few caveats to an IPA. Depending on what region of the country you live in, the rules may be different. For instance, in Vermont, one payer dominates the market and the IPA has no advantage because it can’t collectively bargain. As a result, independent practices in the state are paid in some cases 200 percent to 300 percent less than employed physicians, according to a report. Hays at AAFP also notes that physicians could get unfavorable rates if they join an IPA that doesn’t represent their specialty.

Another potential strategy for independent physicians is hiring an outside billing firm. If this happens, it’s pertinent that the physician stay involved in the process and not just hand off all operations, says Cloud-Moulds. Many times, she cautions, a third-party billing company won’t follow up on denials because they don’t have the time.

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AAFP’s Hays advocates for the use of a consulting firm, saying it’s a more cost-effective strategy than bringing someone on staff or having a full-time outside billing firm. “It’s a one-time fee that maybe you do every year or once every two years for different payers. Your payers aren’t going to negotiate a new contract every year, so it wouldn’t be a huge investment long term,” she says.

### Strength from Value

Another potential leg up for independent practices, strangely enough, is the switch to quality-based reimbursement and for Medicare specifically, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA and other value-based reimbursement initiatives can provide great incentives for independent practices to earn more.

“[You can be a little guy and have top quality,” Madden says. “There are new contracts that will pay you for performance. But if you are not a higher performer, you’re not doing well, and you’re not able to have quality in your practice, you’ll absolutely be left behind.” While many say MACRA will hurt small, independent practices, she says it’s a “great framework” for them to “climb that ladder,” demonstrate quality, and earn more.

### Established Patient Office Visits by Specialty

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### Average Reimbursement

Do you expect that shift in payment methodology from volume to value to be good for your practice, bad for your practice, or neither?

- Good for my practice (12.5%)
- Bad for my practice (29.4%)
- Neither (11.7%)
- I’m not sure yet (46.4%)
In terms of MACRA, the 2016 *Physicians Practice* Fee Schedule Survey reveals a number of practices will have to educate themselves quickly to take advantage. More than 30 percent of respondents say they are fee-for-service and are not prepared for MACRA; 20.1 percent of respondents say they are fee-for-service but are entrenched in fee-for-service; and 19.6 percent couldn’t even identify MACRA. Only 13.1 percent of respondents say they are preparing for the switch, with another 15.9 percent already involved with mostly value-based contracts through an Accountable Care Organization or a Patient-Centered Medical Home.

“One thing to keep in mind, says Cantrell, is that private payer contracts are still predominantly fee-for-service. For that reason, he says, any additional revenue coming from quality will still not overcome the disparity between independent and employed physicians.

**ADVICE**

Experts agree that while it’s harder for an independent practice to get reimbursed on the same level as employed physicians, there is hope. Mullins at AAFP says the one piece of advice she shares with independent physicians is to not be afraid to ask questions and negotiate. “You never get anything you don’t ask for,” she notes. Cantrell says practices should educate themselves on what others in their area have done.

Cloud-Moulds stresses the importance of paying attention to details. She says too often physicians will just sign contracts or go along with contract changes without protesting. Insurance companies will send any contract changes their way on a small postcard to get physicians to overlook them. “Pay attention to those. Go and find out what’s changed,” she says. “Look at your EOBs [explanation of benefits] and make sure you are being paid what they said they are going to pay you.”

Madden takes on a different tone. She focuses on value-based care and says that practices should find out what they are doing that’s worth paying more for. “Are you ahead when it comes to understanding a patient population, offering good programs for them? Are you tracking how you are performing in various areas? Do you have a fundamental understanding of how you are performing in that network?”

Moreover, she says independent practices need to invest in the transition to value-based care to survive in the coming world of MACRA. “If you are not investing in technology, if you don’t have an [EHR], and you’re not interested in quality programs, there is nothing for you in the market and there will be nothing for you in the market going forward. To stay independent, you need to understand the market and what you’re working in.”

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**What percentage of your 2017 revenue do you expect will come through non-fee-for-service contracts?**

- None (25.7%)
- 1% to 10% (35%)
- 11% to 25% (16.5%)
- 26% to 50% (9.7%)
- More than 50% (13.1%)
Have you prepared your practice for quality reporting under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which will reimburse based on quality, practice improvement, resource use, and use of certified EHRs?

- We’re already mostly value-based through an ACO or PCMH (15.9%)
- We’ve done some value-based reimbursement, but we’re still mostly entrenched in fee-for-service (20.4%)
- We’re completely fee-for-service, but preparing to switch to more value in accordance with MACRA (13.1%)
- We’re fee-for-service and not prepared for MACRA (31%)
- What is MACRA? (19.6%)

Given this shift, have you considered any of the following? (Check all that apply)

- Shifting to a concierge medicine model (19.8%)
- Shifting to a direct-pay model (30%)
- Joining an Accountable Care Organization (26.7%)
- Becoming/joining a Patient-Centered Medical Home (20.3%)
- Participating in pay-for-performance initiatives (32.3%)
- Adding ancillary services in the past two years (19.8%)
- Becoming an employed physician/ Retiring (34.1%)

What do you think the effect of MACRA will be on your practice?

- It will help us streamline operations and patient care (9.2%)
- I’m not sure at this point (59.8%)
- It is another initiative seeking the end of independence in favor of collaboration (31%)
About 35 percent of family physician Michael Munger’s contracts with commercial insurers are in value-based care. The Overland Park, Kansas-based family physician plots a marked increase in such contracts to about two years ago.

One of the hardest parts of being successful with value-based care — as is the case with CMS — is making sure that physicians and the entire care team are all aligned with the outcomes that illustrate success.

To manage the health of the patient population they’re serving. For example, practices need to make sure they’re monitoring the health of their diabetic patients, those living with chronic obstructive pulmonary disease, and other chronic conditions.

In order to achieve that level of success, every single member of the clinical team needs to be “rising to the top of their expertise and licensure,” says Munger, who’s also president-elect of the American Academy of Family Physicians (AAFP). At his practice, that means that a care coordinator — a nurse who is working as part of the overall team — reaches out to the patient in a proactive way shortly after their visit to an emergency room, for example. Nurses are also triaging patients’ questions, discussing changes to their medical therapies, and scheduling necessary tests, instead of having patients wait to hear back from Munger or one of the other nine doctors at the practice.

This change didn’t happen overnight, however. What the practice found beneficial was building trust across the entire team. Case in point: Everyone on the team needs to trust that one of the nurses will take ownership of following up to make sure patients are up-to-date on their flu shots and immunizations. And, on a practical level, this teamwork also requires Munger and the other physicians on his team to take time to introduce patients to other members of the care team. To achieve this, Munger takes a couple of minutes to introduce his patients to the care coordinator on his team. He’ll mention that patients should expect to hear from her within six months about their flu shots and immunizations; he and the other physicians at his practice provide these introductions anytime there’s a need for care that’s facilitated by one of the practice’s two care coordinators.

Because various members of the team take ownership for different aspects of patients’ care, each team member is empowered, says Munger. That’s a transformation, compared to the situation a few years ago, when

PAYERS AND PRACTICES PARTNERING ON VALUE-BASED INITIATIVES

Can small practices make it in a value-based world? Payers and experienced practices explain how this shift is possible.

BY AINE CRYTS
patients looked to their doctor alone as being responsible for their healthcare, he adds.

**HOW DO YOU GET THERE?**

Munger’s practice has been certified by the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home since late 2013, so his team has had time to figure out what works best for them. But these lessons are being learned the hard way at small and medium-sized physician practices around the country.

According to Veeneta Lakhani, vice president of provider enablement at health insurer Anthem, her organization has made a commitment to small to medium-sized physician practices for the last four years. The path to success for practices of this size is for commercial payers to assess providers’ readiness to take on risk and the proactive management of the patients in their care. (Forty-six percent of Anthem’s medical spend was in value-based care in 2016, which includes physician groups of all sizes, says Lakhani.)

For example, some of the larger practices Anthem works with have more experience managing large patient panels, whereas some of the smaller practices need “quite a bit of investment” by Anthem to enable them to be successful with value-based care. From a practical perspective, that means that payers have to help practices build the right kind of structure, access to data, and insight into appropriate staffing to achieve success in value-based care, she says.

The payer’s investments include a provider-facing portal with reports and data for providers. The portal also highlights high-risk patients, ER “frequent fliers,” open care gaps, generic drug opportunities, and other actionable information. Anthem’s staff maintain active relationships with their counterparts at physician practices, especially those with high concentrations of Anthem members. Collaborative learning opportunities — such as a recent webinar on getting adolescent patients to come to the practice for well visits and immunizations — are also made available to providers.

Anthem hears a lot of feedback from practices that they’re looking for “payer-agnostic solutions,” says Lakhani. For example, practices are asking for standardized score cards to use for reporting data to different payers. It’s challenging for practices to have to report information in different ways to commercial payers and CMS. That’s where we need “industry alignment,” she adds. Software solutions from vendors can also be helpful in this regard.

Population health management vendors are starting to standardize around measures that are commonly being used in value-based programs, particularly the Healthcare Effectiveness Data and Information Set measures, says Lakhani. “As population health tools continue to mature, they’re finding the commonality across payer programs and streamlining the amount of effort required to participate in multiple programs with multiple measures."

Also on the topic of data, physician practices need to know the care paths their patients are on. With that information in hand, practices can reach out to patients in a proactive way, she says.

At Munger’s practice, the patient experience today is very different than it was a few years ago. Today, a team member at the practice is calling diabetic patients to remind them to schedule appointments and to have their blood work done, he says.

“The path to success for [small to medium-sized physician practices] is for commercial payers to assess providers’ readiness to take on risk and the proactive management of the patients in their care.”

—Veeneta Lakhani, vice president of provider enablement, Anthem

**MEETING PRACTICES WHERE THEY ARE**

Most of the small to medium-sized practices UnitedHealthcare engages with in value-based care contracts are in what Scott Hewitt, vice president of value-based care contracting, calls its “metric-specific programs.” These programs reward practices when they can demonstrate that they’re proactively managing the health of their patients.

In practical terms, this means if the practice gets all of its relevant patients screened for colorectal cancer, for example, the practice receives a bonus check. Hewitt says approximately 40 percent of the payer’s $53 billion in value-based care spend was in metric-specific programs in 2016, which includes physician groups of all sizes, he says.
based care contracts in 2016 was in metrics-based programs with physician practices of all sizes. The payer expects to have more than $65 billion in value-based contracts in 2018.

As practices gain more experience in value-based care, they’re more equipped to take on arrangements where they’re paid for bundled or episodic payments, he says. For example, that could include accepting a lump sum for a knee or hip surgery. Hewitt says that while success in the metric-specific programs doesn’t automatically mean that a practice will be able to move to a bundled payment program, experience in the metric-specific programs gives practices a better understanding of ways to ensure that their patients are receiving optimal care in the right place, at the right time, and at the right price.

Approximately 20 percent of UnitedHealthcare’s contracts are in this second type of value-based contracts. The remaining 40 percent of the payer’s value-based contracts are with large hospitals and integrated delivery networks.

Practices look to UnitedHealthcare to help determine members’ gaps in care and best practices in providing that care and pharmacy prescription patterns. This information is sent to providers electronically or by mail, since there are still many providers that don’t have access to the Internet, says Hewitt.

His advice for practices that want to increase their success rate in value-based care includes:

- Engage with payers to ensure that you have mutually aligned goals. “You can better care for members when you know how [you] can work together to achieve that,” Hewitt says.
- Get as much patient data as possible from payers.
- Implement processes within the practice to provide the highest level of care.
- Determine with payers where there may be inefficiencies in the delivery of care. “Everyone thinks they’re providing the most efficient care,” he says. “Unfortunately, that’s not always the case.”

THE BIG PICTURE

While Donald Crane, president and CEO of CAPG, a leading U.S. trade association for physician organizations practicing capitated, coordinated care, says that commercial payers are largely following the direction set by former-Secretary of Health and Human Services Sylvia Mathews Burwell in March 2016. Burwell announced that 50 percent of Medicare payments would be tied to quality by 2018. Yet, some of the organizations members tell Crane not all payers are embracing this level of value-based care.

“Where there are risks, there are rewards,” says Crane, adding this is the reason some payers are resistant to embrace value-based care in their contracts. Payers’ embrace of value-based care largely depends on the payer’s strategic focus. If a payer wants to have more control over the delivery of care, fee-for-service is probably a better fit. However, if the payer’s focus is on eliminating waste, coordinating care across the continuum, and achieving higher quality scores and better patient care, they’re moving toward value-based care, he says.

Value-based care is “here to stay,” says Lakhani, in spite of uncertainty about the future of healthcare reform.

While no value-based care program is “designed in perfection,” she sees a shift toward moving risk from payers to providers, including awareness by payers that many decisions about patient care are “better handled with much better results in physicians’ hands. That’s a shift that’s positive and [it’s] here to stay.”

“As practices gain more experience in value-based care, they’re more equipped to take on arrangements where they’re paid for bundled or episodic payments.”

–Scott Hewitt, payer executive
The effort to repeal and replace the Affordable Care Act (ACA) is like the game Jenga, in which players must carefully pull blocks of wood from within a tower and place them on top without the whole thing collapsing.

Republicans in Congress and the Trump Administration want to remove some unpopular elements of the ACA, such as the individual mandate, leave others in place, and avoid having the whole individual insurance market collapse. Physician groups are watching nervously from the sidelines and urging the Republicans to retain key elements of the ACA. Physician groups are also trying to gauge what the impact of a repeal would be on their patients and practices.

With no clear consensus plan in place yet, new replacement proposals were being floated almost daily in late January. One would allow states to choose whether to keep the health insurance exchanges. There is one thing John Meigs Jr., president of the American Academy of Family Physicians, is sure of: “If they repeal the ACA without anything to replace it, it is going to create real problems,” he says.

“In primary care, we still see the patients who don’t have insurance,” Meigs explains. “We take the loss or do some kind of discounted fee schedule to try to accommodate them. But it is extremely difficult to get an uninsured patient in to see a specialist.” Also the ACA has significantly increased the number of people accessing preventive services such as mammograms and colonoscopies that they had been putting off.

“Now they could go back to putting those off again,” he says. “It could have a snowball effect.”

WHY CRAFTING A REPLACEMENT IS SO DIFFICULT
Anne Phelps, principal and U.S. healthcare regulatory leader for consulting firm Deloitte, says she doesn’t think replacement legislation will come in a single 2,500-page bill. “It is more likely to be a series of steps in terms of the budget process and regulatory changes.” Republicans are talking about providing a base level of coverage — a revamped high-deductible/health savings account (HSA) plan with catastrophic coverage and lower premiums, she says.

Upon taking office, President Donald Trump immediately issued an executive order that instructed the U.S. Department of Health & Human Services to use its authority to begin scaling back ACA rules, including how hardship exemptions to the individual mandate are granted and allowing states to charge more fees to Medicaid enrollees.

The problem for his administration and Republicans in the U.S. Congress is that insurers have relied upon the individual mandate and government premium subsidies to offset the cost of covering people with pre-existing conditions. Insurers could be unsettled by the prospect of changes even if they are delayed a few years. Their participation in the individual insurance market is optional, and their plans and prices have to be set months in advance of when they are sold to consumers, explains Sabrina Corlette, a research professor in the Center on Health Insurance Reforms at the Georgetown University Health Policy Institute.

Any policy change that asks insurers to come up with plans or prices for 2018 without knowing in advance what the rules of the road are going to be sets the stage for them to either (a) decide it isn’t worth it and focus on other lines of business (Humana, a large insurer based in Louisville, announced recently that it’s dropping out of Obamacare exchanges in 2018, citing the tenuous marketplace) ; or (b) choose to participate but raise their premiums to account for the higher level of risk associated with the uncertainty, she says.

In either of those scenarios, the downstream effects are going to vary from market to market, Corlette said. “You may have some pockets that remain viable, where consumers are still going to be able to buy coverage, but you may have other parts of the country where they are not. Insurers are raising big red flags to Congressional leaders to say, ‘If you repeal the individual mandate and the subsidies, with or
Meigs said. “But now we have to get down to reality.”

Politicians like the idea of selling across state lines because it sounds like they are going to get rid of expensive regulations and standards that are driving up the cost of premiums, Corlette says. But the real drivers of premium increases are medical and pharmaceutical expenses, she adds.

ADVOCATING FOR PATIENTS

Deloitte’s Phelps said physician groups are concerned about making sure that not only is there stability in the market, but also that individuals, notably the nearly 9 million enrolled in exchange plans and the nearly 10 million enrolled under Medicaid, have access to coverage.

But Phelps adds that many physician organizations understand that repeal is likely to happen, so they have switched their focus to what a replacement plan should look like, including the balance between federal and state, where dollars should go with the credits and subsidies, and what to do about the Medicaid population.

Many physicians are voicing concerns about what might happen if the ACA is repealed without a replacement plan that allows consumers to find comparable and affordable insurance.

“I have taken care of patients prior to the ACA and I have taken care of patients afterwards and I have seen so many examples of the difference,” says Mona Vishin Mangat, who has an allergy and immunology solo private practice in St. Petersburg, Fla.

She recalls one patient with severe asthma she has been seeing for close to 10 years. Prior to passage of the ACA, he couldn’t afford medication or tests. Once the exchange opened, he got insurance and was able to get all the medications he needs and hasn’t been in the hospital for three years.

“He was just in my office last month, and we were talking about what we are going to do if the ACA is repealed,” she says. “There is a lot of disbelief among patients that it is going to happen. But it is a very real fear among patients and physicians.”

Mangat, who is active with a pro-ACA advocacy group called Doctors for America, said it is rewarding to her professionally when insurance coverage is not a limiting factor in her treatment of patients.

She also thinks about it from a business standpoint with four employees on exchange plans.

“It is a wonderful thing to know your employees can get the care they need,” Mangat says.

She is skeptical of Republican proposals to expand access through plans with high deductibles and HSAs. “HSAs are fantastic for people who have money,” she said, “but if you make $10 per hour, there isn’t going to be money in that health savings account,” she said.

It is clear that Republicans are grappling with the reality that they have to come up with something to replace the ACA. “I thought it was interesting when Trump, as president-elect, said he wanted universal coverage,” Mangat says. “I’ll sign up for that. Our patients need access to care.”

So what should physician practices be doing to prepare for the changes ahead? Munzoor Shakih, director in the healthcare practice at business and technology consulting firm West Monroe Partners, says the economic realities of healthcare are much stronger than any of the political noise we are hearing now.

“It is easy to get caught up in the changing dynamics and uncertainty of it all,” he says. “My advice is don’t get caught up in it, because whatever happens we will still have to deal with a population that is aging and not very healthy. I would tell physicians’ practices to stay the course in terms of preparing for those economic forces: get ready for bundled payments, cost containment, care coordination, and providing a superior patient experience.”

If the new administration and new Congress want to pass a resolution to say they repealed Obamacare and then fix some of the ACA’s problems so that they can now call it Trumpcare, McConnelcare or Ryancare, that’s OK with the AAFP’s Meigs.

“I don’t care what they call it,” he says, “as long as they take care of our vulnerable populations.”

“I thought it was interesting when Trump, as president-elect, said he wanted universal coverage. I’ll sign up for that. Our patients need access to care.”

—Mona Vishin Mangat, MD