Small Practices Forging Ahead in Value-Based Care

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Most physicians are skeptical of value-based care, but these four practices are proving to be outliers. What have they learned about their experiences?
Source: Physicians Practice

There is a lot of skepticism in the physician world on whether or not "value-based care" — where providers are reimbursed based on quality measures, rather than quantity — can work.

In an upcoming, yet-to-be-released survey from *Physicians Practice*, more than 50 percent of physicians (1,314 were surveyed) said value-based care was a good idea in theory, but difficult in practice. A smaller group, approximately 20 percent, went so far to say that it was a bad idea that would never succeed. Only 6 percent of respondents said it was a good idea and good for patients. *For full results from our 2016 Great American Physician Survey, visit PhysiciansPractice.com in early September.*
Yet despite the fact that value-based care may not be winning the hearts and minds of physicians across the country, CMS is attempting to do just that before those doctors have to get on board. The agency recently proposed a rule to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), mandating two tracks for physician reimbursement — the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).
Most physicians will fall under the former, where they'll be scored on quality measures, usage of technology, clinical improvement, and cost utilization. APMs require participation in Medicare-based payment models such as accountable care organizations (ACOs) and Patient-Centered Medical Homes (PCMHs). In the past few months, CMS has spent a copious amount of time to get physicians on board, through webinars, speeches from officials at professional meetings, and more.

For physicians, this upcoming reality means there is simply no avoiding value-based care. Clive Fields, physician and owner of Houston-based Village Family Practice, says, "CMS has said by 2018, 70 percent of Medicare patients will be in value-based arrangements." Fields, who runs a side business consulting practices on implementing value-based care models, adds most physicians are in these kinds of arrangements already, possibly through Medicare or a private payer. "They are in value-based contracts; I promise they've all signed up for value-based incentives. They aren't doing anything with them because they're all focused on fee for service."
While many practices are sitting idly by and ignoring value, there are some small practices taking a more proactive stance by not waiting for the MACRA hammer to drop. *Physicians Practice* spoke with four small practices that have dabbled in value-based care, one way or another. They shared with us the benefits and challenges of value-based care as well as advice they have for their peers.
Family Medical Specialists

Located in Plant City, Fla., where the snowbirds fly in the winter, it's not surprising that family medicine physician Michael Paul Gimness' practice has a patient panel composed of nearly 53 percent Medicare patients. As such, Gimness, who is a solo doctor with a nurse practitioner on staff, has gotten on board with value-based care. Any cut into his Medicare reimbursement would do significant damage to his practice's bottom line.

"I saw the way healthcare was going," says Gimness. "If you are not looking [ahead] to [MACRA], in 2019, 2020, 2021, there is a 9-percent decrease in reimbursement for the bottom 12 percent [of practices] … I can't afford to take that kind of cut because my staff will take that cut. Any decrease in pay comes out of my bottom line. In order to stay in practice and in medicine, I have to embrace this. Any physician who doesn't embrace this, they will be financially struggling in the next couple of years."

Gimness is using CPT code 99490 to manage care for his population of patients with two or more chronic health conditions. Using an IT system from CareSync, the practice extracts data from its EHR to facilitate chronic care management (CCM) for eligible patients. For those patients with two chronic conditions, the CCM code, as of Jan. 1, 2015, has paid Medicare providers to check the boxes for various proactive face-to-face, electronic, and phone-care coordination services (preventive care measures, medication reconciliation, discharge follow up, and much more), with the ultimate goal of decreasing hospitalizations, improve outcomes, and lower costs.

For its efforts, Gimness' practice makes $45 per patient (minus what he pays in contracted rates to CareSync). The biggest challenge, he says, is constantly being hands-on with patients to ensure they are being compliant with their care and staying out of the hospital. At the end of the day though, he is a firm believer in population health management, "This is beneficial for my patients, it's beneficial for my practice. It's a win-win."

Willamette Heart and Family Wellness

Across the country, in an area where pioneers once traveled the Oregon Trail, Willamette Heart and Family Wellness, a family medicine practice in McMinnville, Ore. with a single physician, two nurse practitioners and one physician assistant, is acting as a forerunner of its own. Like Family Medical, it too is using CPT code 99490 to manage care for its primary-care and cardiac patients and is moving in the direction of value-based care.

"Chronic care management is [valued-based care] that you can profit off immediately and add to your bottom line without adding to your workload," says Sarah Hurty, practice manager at Willamette Heart and Family Wellness. "It doesn't matter what cool thing you add on right now that Medicare pays for, that adds to patient value, to preventive care, to a wellness approach … if you don't have chronic care management in place, you are going to get penalized up to 9 percent. It makes no sense to add the icing to the cake if you don't have the cake. Chronic care management is the cake."

The top challenge with the practice's effort in CCM, according to Hurty, is getting 100 percent doctor buy-in, in order to change their processes and transform the practice. Another one is getting patients on board, especially with the copay required of them. "If it costs the patients anything, you have a little bit of a barrier right there," Hurty says. "They are getting charged for something they can't see or they think you are doing already."

Regardless of these challenges, conducting CCM correctly will decrease hospitalizations, add value to patient care, and move practices into the direction Medicare is going, says Hurty. "It's low-hanging fruit," she says, adding it will help providers buy time until the real challenges with value-based care begin.

Talcott Primary Care

Just within the city limits of Chicago, Talcott Primary Care, a five-provider practice, cares for a combination of Medicare and commercially insured patients, says Steven Pearlman, a family physician. He says the practice has always been ahead of the curve, whether it was adopting practice management software in the mid-1980s or an EHR system in 2006. Value-based care has been no different. They are part of an ACO through a local, affiliated health system, Presence Health, and have provided care management metrics through CPT Category II coding, "which facilitate data collection for the purpose of data management," according to the California Quality Collaborative.

While their efforts haven't been as financially rewarding as Pearlman and his team would have hoped, there is a reason the practice is maintaining efforts in value-based care. "We try to be aware of some of the changes coming down the road and then try to plan for it, so we're not in shock," says Pearlman. He also says the practice sees value-based contracts as a way to continue to develop long-term relationships with its patients, rather than the churn of fee-for-service care. "We're old school, we don't like to cram four patients in an hour."

The biggest challenge of value-based care is the added level of documentation required and the accompanying time commitment, says Pearlman, who complains that note bloat in EHRs is a very real problem.

Pearlman's advice for his fellow small-practice physicians is to seek help through strategic alliances. His practice has started to work with Fields' VillageMD to understand best practices and how to successfully implement a value-based care model that can be financially viable. He says without help, small practices' hopes of succeeding in a MACRA environment will face steep odds. "Quit being a lone ranger. It's not going to get you very far. Even the Lone Ranger had Tonto," he says. "There is no silver bullet, but learn from each other."

TruHealth Family Care

In Fayetteville, Ark., Mark Miller, a family medicine physician, heads up his own small practice and cares for mostly Medicare (40 percent) and commercially insured patients, with a few self-pay patients mixed in. He employs two advanced practitioners, one of whom is full time and the other part time. "We don't have a booming practice, we like to take our time to see people and don't like to rush people through," he says. "I'm not a volume-based guy. I don't like seeing 50 people per day."

It's no surprise then that his team would be involved with value-based care, initially through participation in an ACO and currently through a clinically integrated network (CIN). Like Pearlman, the ACO didn't provide any kind of financial benefit for his practice and so he dropped out last year. With the CIN, Miller is working with fellow independent physicians like himself, employed physicians, and leaders at Northwest Health Systems in Arkansas to create quality-care incentives.

"Once we have a set number of providers, this fall, we're going to go to the payers — and we already have some lined up — to start contractual talks," says Miller. To get fellow physicians to participate in the CIN, Miller says he is selling physicians on the concept of more face time with patients. He also says there is no front-end risk for physicians. "There is no entry fee. There will be a fee later, but it will be taken out of any money you receive from shared savings," he says. Another benefit he says is that physicians in the CIN get access to claims data.

Many physicians, Miller says, are worried about this last part, sharing information with people who may be their competitors. He says that's a valid concern. Overall though, Miller is bullish on value-based care and says, "This is the only way to contain costs." His advice to fellow small-practice physicians is to get involved and provide input. "When you're involved, there is a lot of education about the process that you get by default. That has been beneficial for me to learn how it works."

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