

# Survival of the Small Medical Practice in the Evolving American Health Care System: Flourish or Fold?

Exploratory Paper

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## Introduction

The American Health Care System continues to change at a rapid pace. Federal and state regulatory efforts designed to reduce cost, improve quality and expand access to care represent a significant source of complexity for small, private medical practices to navigate. Evolving payor requirements to move toward value based care and ensure appropriate care is delivered in the right setting at the right time, new payment incentives, and reimbursement and contract changes all require detailed analysis. The growth of new and evolving technology, compliance, privacy and security demands, and new mandates for health information systems and clinical practice improvement in the era of the proposed Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rule underscore the need to manage vast change and multiple competing priorities. The Centers for Medicare and Medicaid (CMS) have described a medical practice as “small” if it has 15 or less clinicians. (Strubler). The small medical practice, which has been the hallmark of the American health care system, is now facing unprecedented extreme pressure, to evolve itself in this environment, in order to remain financially viable and to survive and thrive in this new era.

## Objectives

This paper will explore recent changes in the American health care system, assess physician employment trends over time, review the potential impact of the proposed federal MACRA rule, discuss the future viability of the small private medical practice, and share best practices and recommendations for private medical practices’ consideration to be successful in the evolving American health care system.

## Research Methodology and Background

The research methodology used will be a literature search. The time frame covered will be from 2009 to present. Stakeholders in the American health care system are many. These include physicians, hospitals, health care professionals, administrators, electronic medical record (EMR)

vendors, nurses, medical assistants, advanced practice practitioners (nurse practitioners and physician assistants), medical practice staff, nursing homes, skilled nursing facilities, rehabilitation centers, home care agencies, hospice providers, insurance payors, employers, pharmaceutical companies, laboratories, and other medical device vendors, as well as federal and state entities and consumers/patients. This lengthy list is indicative of the complexity of the American health care system.

## Change

Health care is a challenging and complex field, given the scope of medicine in general and ongoing medical research efforts, but over the past seven years, from 2009 – present, there has been an explosion of recurring change and significant growth in the complexity of the American health care system. The pace and scope of these extraordinary changes have contributed to the evolving role of physicians and have affected the small medical practice, with many posing the question, “Can a small medical practice survive and be successful in this new model of the American health care system?”

It is helpful to briefly examine the timeline of the major changes that have occurred and seek to understand the impact on physicians and small medical practices. At the federal government level, the initial catalyst was the Patient Protection and Affordable Care Act (PPACA), which was passed in the Senate on December 24, 2009, and passed in the House on March 21, 2010. It was signed into law by President Obama on March 23, 2010 and upheld in the Supreme Court on June 28, 2012. The acceleration of change in the health care environment was set in motion. (History and Timeline of the Affordable Care Act). The American health care system experienced even more change with the transition to the International Classification of Disease 10<sup>th</sup> Revision (ICD 10) effective October 1, 2015 supported by the CMS and the National Certification on Health Statistic (NCHS) for medical coding and reporting (Dimick). Likely the most significant change

occurred on April 14, 2015, when the Senate passed the MACRA, which had been passed in the House on March 26, 2015. This action eliminated the Sustainable Growth Rate (SGR), which had been in effect since it was established in the Balanced Budget Act in 1997, and triggered new changes in the Medicare payment system for physicians. (Rudolf, Maxwell and Madsen).

At the current time, health care constituents, including small medical practices, await the final decision by the CMS on whether the MACRA will go into effect for the proposed January 1, 2017 performance year. Many have contemplated its potential impact on small medical practices, with some claiming it to be an improvement, while others have stated it will lead to the demise of private practice medicine in general.

Following federal health care policy, the Department of Health and Human Services (HHS) set a goal to link 30% of Medicare fee for service (FFS) payments to quality or value through alternative payment models (APMs) by the end of 2016, and to expand this to 50% by 2018. Examples of APMs include initiatives such as bundled payment models and accountable care organizations (ACOs). MACRA's new physician payment system includes Medicare base payment rate changes of 0.5% increases each year from July 2015 to 2018. To receive 100% of Medicare's annual update to the payment rates, physicians must meet high quality and low cost established goals. Over time, the system will implement payment penalties designed to incentivize lower performing physicians to improve. In addition, MACRA includes two options under the CMS Quality Payment Program (QPP): 1. The Merit-Based Incentive Payment System (MIPS) or 2. An alternative path whereby physicians may choose to join an advanced alternative payment model (AAPM). (Rudolf, Maxwell and Madsen).

Under the QPP, the MIPS seeks to combine and expand the current federal reporting requirements. This includes the Physician Quality Reporting System (PQRS), the Value Modifier (VM), (which uses cost and quality data reports developed from physicians' Medicare claim

submissions to assess resource use), Meaningful Use (MU), which is to be modified into a new replacement category called “Advancing Clinical Information,” and lastly a new category called Clinical Practice Improvement Activities, (CPIA). A composite score for a physician will be created based on performance in PQRS (30%), VM (30%), MU (25%) and CPIA (15%). The other pathway, involves the option for a physician to join an advanced alternative payment model (AAPM). The AAPM option includes a 5% annual bonus from 2019 – 2024 if physicians meet “qualifying participant” (QP) status in the AAPM. This involves metrics of meeting both revenue and patient volume thresholds that include financial risk. If a physician meets QP status, then he/she does not have to report MIPS data. Examples of AAPMs encompass several options, including Track 3 and 4 ACOs. For year 2026 and beyond, QP providers in AAPMs payment rates will increase by 0.75%, while rates for other providers will increase annually by 0.25%. (Rudolf, Maxwell and Madsen).

Due to feedback on concerns about the impact of MIPS on small practices, on April 27, 2016, CMS shared changes intended to streamline and simplify the proposed rule. Despite these modifications, estimated effects of MIPS predicted that it would result in 2019 financial penalties for 87% of solo and small practitioners, while resulting in rewards for 81.3% of large practices with 100 or more physicians. Anders Gilberg, Medical Group Management Association (MGMA) senior vice president of government affairs, was quoted in *Medscape* as saying, “Those numbers are inconsistent with the congressional intent, and inconsistent with what CMS has been saying.” He advocated for a program that would provide a level playing field for all physicians to be successful under MIPS, regardless of medical practice size. (Kuhrt)

In May 2016, members of Congress strongly commented to CMS that MACRA should be modified to ensure it does not negatively impact small medical practices. Andrew Slavitt, acting administrator for the CMS, testified on May 11, 2016 at the House Ways and Means Health Subcommittee to address concerns. He shared that MIPS will be far easier going forward than the

original proposed Stage 3 MU requirements. He reiterated that it is important to CMS that solo and small offices can also be successful in the new model. Dr. Thomas A. Mason, chief medical officer in the Office of the National Coordinator for Health Information Technology, shared at the May 7, 2016 American College of Physicians Annual Meeting, that MACRA regulations have allocated twenty million dollars a year for five years beginning in 2016 to provide help for solo and small medical practices to convert to MIPS or AAPMs. (Twachtman).

Slavitt has stated that CMS welcomes feedback on the proposed rule and that the intention is to be fair to all physicians. He shared skepticism regarding the previously reported negative MIPS financial penalties for solo and small practitioners, and indicated that he did not believe this data was true, and also stated that “the numbers are based on 2014 data, when most small and solo practices were not reporting quality data...” As feedback continues on the proposed rule, Slavitt shared five recommendations for physicians to consider:

1. Keep focus on patients and patient care, as it is CMS’ job to streamline the MACRA program
  2. Physicians will ultimately have the decision making authority to select quality metrics “that are right for their practices”
  3. Physicians should take opportunities to participate in alternative payment models.
  4. Physicians will not have to report on MACRA until spring 2018
  5. CMS welcomes feedback from physicians
- (Finnegan).

Multiple opinions on MACRA’s impact on small and solo practice physicians persist. One end of the spectrum is the statement from Dr. Jayne on the Healthcare IT News and Opinion blog (HIS Talk), who stated that MACRA may be the “last straw for small and independent practices...the requirements are daunting, especially for practices who haven’t been at the

forefront of payment efforts” (Elation). Lastly, it is important to be aware that in addition to the financial penalties associated with MIPS, CMS will make the results of the QPP publicly available on the Physician Compare website, with the intent to help patients make choices about provider selection. (Strubler).

### Physician Employment Trends

While we await the final rule on MACRA from CMS, it is important to examine what has been happening with physicians in the United States, in terms of how a physician earns his or her livelihood and what patterns can be observed over recent time. A review of the trends in physician employment and the changes over time in the number of physicians as owners of private practices, as compared to physicians as employees at a hospital or other health care delivery organization is helpful in examining the current health care state of affairs. There has been much press and focus that a large majority of physicians are quickly exiting private practice for hospital employment. We have seen several varying perspectives and predictions as to what model of new physicians’ compensation will become predominant in the future. In July 2015, Accenture, a global management consulting, technology and outsourcing company, completed an analysis and online survey of US physicians and boldly predicted that many US physicians would leave private practice for hospital employment, and stated that by the end of 2016, “only one in three doctors will remain independent.” While we have not seen such a drastic change, reimbursement pressures and overhead costs to support a private practice were the two most significant factors cited by physicians who were surveyed as the most compelling factor to influence them to move away from private practice. The growing complexity to operating an independent practice and the need to change to remain profitable and relevant underscore the pressures on the small medical practice. (Many U.S. Doctors will Leave Private Practice for Hospital Employment).

Hospitals are also greatly challenged by the significant changes in health care and are affected as a key stakeholder as related to recent trends in physician employment. Paul Keckley, Managing Director for the Navigant Center for Healthcare Policy and Research, has offered further perspective on physician employment by hospitals, stating that "...employing physicians is not a slam dunk," citing the unique challenges hospitals face. Physicians want clinical autonomy, efficient technologies, and compensation that reflects their experience and performance, and that is not based only on the volume of services rendered. Navigant collaborated with the Healthcare Financial Management Association and found that specifically for hospital based medical practices, efficient operations, effective physician compensation methods and the ability to recruit new physicians were the top three concerns cited by hospital administrators. Hospitals that own medical practices have seen that the critical success factors for long term profitability include cost containment and practice efficiency, as well as patient satisfaction and the ability to offer convenient services to meet health care consumers' desires. As health care continues to change, hospital employed practices role will further evolve. (Keckley).

The American Medical Association (AMA) *Policy Research Perspectives* study on physician practice arrangements found in a 2012 survey that while much press has been focused on a shift toward hospital employment, the study found that 53.2 percent of physicians were full or part owners of their practice in 2012, 41.8 percent were employed by a hospital or health system organization and 5 percent were independent contractors. 23 percent of physicians worked at practices that were at least partially owned by a hospital and 5.6 percent were directly employed by a hospital. In terms of practice type, the AMA study found that nearly 46 percent of physicians were in a single specialty practice. Multi-specialty groups accounted for 22 percent. Of that number, 36 percent of internal medicine and 28 percent of family medicine physicians were in a multi-specialty group. In looking at practice size, almost 60 percent of physicians worked in practices that had less than 10 physicians, while 16 percent were in groups of 10 to 24 physicians

and 7 percent were in practices with 25 to 49 physicians. There were 12 percent of physicians in groups of 50 or more physicians. (Kane and Emmons 1-6).

While the results of the 2012 AMA study show that the majority of physicians still work in private practice, in looking at changes since earlier surveys, there has been a definite decline in the number of physicians who are self-employed, with an 8 percent drop observed from 2007 to 2012. The trend toward hospital employment may be related to a hospital strategy to employ primary care physicians to ensure strong referrals for inpatient specialty services, and after the PPACA, the resulting increase in health insurance coverage since 2014. (Kane and Emmons 4-5). Brooks further examined an updated AMA *Policy Research Perspectives* Report in July 2015. Andrew W. Gurman, MD, AMA president-elect, released a press release stating that “These data show that the majority of physicians (60.7%) were in small practices of 10 or fewer physicians, and that practice size changed very little between 2012 and 2014....” The number of physician owned practices has declined as compared to thirty years ago, when greater than seventy five percent of physicians worked in small private practices. (Brooks).

In addition to an increase in hospital employed physicians, there are other reasons for this change. There has been a decrease in the number of solo and small medical practices overall. The shift from small to large medical practices has been affected by a “cohort effect,” in which younger physicians are 2.5 times less likely than older physicians to be in solo practice, and as solo doctors retire over time, they are not being replaced in the current health care system. Younger doctors seem to prefer larger practices that may offer a greater opportunity for work-life balance and a steady and predictable income. In addition to age differences, the changes in the health care market are driving some physicians toward employment with larger practices which may have a greater ability to negotiate with payors, maximize economies of scale for purchasing, and have the internal organizational structure to track and manage quality data and orient staff to support care coordination initiatives. (Squires and Blumenthal).

Private practice has both rewards and challenges. The American Academy of Family Practice (AAFP) survey from data as of December 2013 also showed some similar trends as the AMA survey, noting that over the past 25 years, the number of active AAFP physician members who identify themselves as “employed” physicians, meaning those who may have a hospital or a health system employer as opposed to those physicians who are owners of their medical practice, has increased from 29 percent to 63 percent. Sharing a perspective from a rural family practice in Missouri, Dr. Peter Rippey of Missouri shared the challenges being faced by his small family practice of seven physicians including uncertainty of the health care market due to the PPACA, challenges related to ICD 10, electronic health records, working to lower overhead costs while trying to support a family, and the need to pay down medical school debt. The positives cited as being in private practice include the ability to deliver low cost, efficient care. Especially in rural areas, private practice is an alternative for patients who do not want to drive an hour or more away to receive care at an emergency room or urgent care setting. Physician autonomy and control of what hours to work, what scope of services to provide, and the ability to take time off for vacation or CME conferences are items that the physician can control. In March of 2015, Dr. Peter Rippey had written this blog and shared uncertainty about whether or not he would stay in the rural private practice or seek employment elsewhere. (Rippey). Efforts made by the author to contact Dr. Rippey for further discussion were unsuccessful, however, based on an internet search, it appears he has relocated to a larger integrated delivery system in South Carolina.

Given the trends and legislative action toward a value based health care system, what is the viability of the small private medical practice, as a continued health care player in the US health care system and what is the future of small physician practices? Physician practice owners have many questions, especially depending on their specialty. What are the current models of success and what short term and long term strategies can be undertaken? Lastly, what evidence exists that

demonstrates the value of small private practices that are owned by physicians that signal the potential for positive outcomes in the future?

#### Emerging Models of Medical Practices as Alternatives to Hospital Owned Practices

Beyond traditional practice, as we have seen a transition from solo and private practices to hospital employed physicians, there are some newly emerging medical practice models that retain physician autonomy. This includes single and multi-specialty “mega” groups where physicians can continue to stay in their own office and retain control over their practice. Some examples of single specialty large groups that have formed include Capital Digestive Care, a group of 57 gastroenterologists in 16 offices that established in 2009, and The Centers for Advanced Orthopedics (The Centers), which was created through a merger of over 130 orthopedists in 46 locations, including 35 in Maryland. (Harder).

In more closely examining the formation of The Centers, physician practices interested in the merger underwent a “vetting process” and Dr. Nicholas Gross, President of The Centers stated that “...we kept the ones we felt practiced great medicine.” It took three years to finalize the full merger and in the model each member practice must contribute funding to the larger organization. Efforts are made to ensure overhead expenses are kept low. Physician autonomy is retained. The Centers employs about 1200 staff and there is a single benefits package, a single tax ID and billing system. The group has saved on expenses including 30% on malpractice rates and injectable drugs. In addition to savings, the larger group has been able to negotiate with more leverage with insurance payors. Dr. Grosso, referring to insurance payors, noted that “Suddenly, they are taking our calls.” (Harder)

A differing example is Privia Medical Group that began in February 2014 with 143 physicians in the Washington DC area. An early focus of the group was to implement a population health model. Participating physicians are partners and co-owners under one tax

identification number, but still have autonomy over their staff and practice. Governance is maintained through a physician-led board of governors. In this model, physicians are compensated based on the revenue they collect. Individual revenue is increased based on rewards for quality care. Expenses have been reduced through improved negotiation for better malpractice rates, centralized billing and improved economies of scale through group purchasing. Privia uses Athena Healthcare as their common EMR, which offers tools to promote and implement population health management. This includes a patient portal, data warehouse, outbound call campaigns to patients and online health risk assessments for patients. The typical time frame for a new medical group joining Privia to “go live” is five to six months. Once the “go live” date occurs, Privia Medical Group will begin collection of its management fee, which was not disclosed in the article. The model includes partnership with hospitals, sub-acute facilities and home care agencies with local primary and multi-specialty care where physicians are rewarded for quality care and payors appear to desire this type of value based model. (Harder).

A third example of a developing model in health care is a movement in North Texas where more than 500 primary care and 600 specialists physicians joined together to care for more than 75,000 patients in an organization called TXCIN. The group has open membership and each practice maintains its own electronic health record but a technology platform exists that integrates data to focus on cost reductions and works to improve quality. There is a peer review type of system yet the physicians remain independent. TXCIN does not engage in reimbursement negotiations and therefore no regulatory review is required. There are 1,135 medical practices currently involved. Physicians are able to maintain their internal workflows and infrastructure while attaining a greater ability to work with payors who recognize that cost savings are possible. Shared system data help identify best practices and efficiencies, as well as cost reductions. This system also helps to identify the most effective physicians and best practices, so that referrals can be directed to those doctors. As part of this change, the role of specialists in controlling health

care consumer spending and the amount of influence that specialists have on patient utilization of health care resources has been identified. Efforts will continue through data use to enhance clinical guidelines and to strengthen patient education efforts so that consumers can make informed decisions. For the physicians involved who value autonomy and the ability to maintain independence, TXCIN has shown to be an opportunity that provides leverage and allows a pathway to achieve cost reduction and quality of care enhancements. (Shyrock).

“Concierge Care,” is yet another evolving model of health care delivery, in which patients pay a physician directly, without use of an insurer and receive membership-like benefits of increased time with the physician, greater access and individualized attention. The American Academy of Private Practice Physicians (AAPP) conducted a survey of over 700 physicians and practice managers and found that 46 percent indicated that they would consider changing to direct pay, concierge care or another form of membership model of health care over the next three years. The reasons cited for this include a perceived ability to spend more time with patients in these models and to remove and separate the insurance payor system from the delivery of health care. In the study, 81 percent of the concierge practices reported on average that they spent 30-60 minutes with patients, as compared to 15-20 minutes spent by physicians at traditional insurance based medical practice settings. In addition, preferences for specific technology differed among settings. The concierge practices were interested in online scheduling, patient portals, online billing and payments and credit card on file, as compared to traditional practices that were interested in improved claims management, financial reporting and specialty electronic health records. There are pros and cons of each model for consideration based on a physician’s specialty, location, competitive position and age. (McCarthy).

Population health management and the impact on health care and on private practice is still another factor for consideration by small medical practices. Population health strives to identify groups of patients with specific health conditions and to implement strategies and tools to assist

patients toward the goal of improved overall health and positive health care outcomes. The aging population of the US is one compelling reason to implement population health management to develop a system that can target aging patients with multiple chronic conditions in an effort to work with patients and strive to prevent more serious and costly health care concerns in the future. Small private practices are often challenged to implement these strategies due to limited resources for staff who are dedicated to calling and reaching out to patients to follow up on chronic care management related to medication compliance, exercise, diet and follow up appointments. Some small practices also do not have the resources to implement a patient portal that can be used to send emails to patients and provide online tools so patients can monitor and view their health record, lab results and send non-urgent email messages to the practice for assistance. In addition, there is a certain cohort of aging patients who do not have access to the internet or a computer and are not trained or able to use email. (Lewis).

Other challenges exist based on the location of the practice and type of community setting the practice resides in. In poor communities, patients struggle to pay for prescriptions and many lack transportation to get to doctor appointments. These barriers may appear to be patient non-compliance, but often the root cause is related to financial concerns and lack of social supports that impede the ability for successful population health management efforts. In other areas of the country, there are pay for performance initiatives that reward physicians for meeting and exceeding quality metrics such as tobacco cessation, blood pressure management and diabetes control. There is a balance to cover the costs of these initiatives as many require staff and technology. Some physicians are looking for insurance payors to offer more innovation in terms of per member per month payments for such initiatives, in addition to the established fee schedules for patient visits and services rendered. It is anticipated that the move toward population health management will continue with a focus on diabetes, congestive heart failure and chronic obstructive pulmonary disease. (Lewis)

Dr. David Nash, Dean of Population Health at Thomas Jefferson University cites four key strategies that private practices must address:

- Managing test ordering behavior- this includes physician awareness of the medical necessity of a specific test, as well as implementation of work flows in at a medical practice to take action to confirm if a specific test has already been ordered by a different provider who has also cared for the patient. Such actions contribute toward improved coordination of care for the patient, as well as can contribute to less waste and reduction of unnecessary health care expenses with improved diligence. A negative impact that could also result relates to a decrease in revenue streams for the owners that provide testing, such as lab and imaging organizations.
- Coordination of care with other providers- this includes a focused approach to collaborate and reach out to other providers who are involved in the patient's care. These efforts can serve to support improved data exchange, again reduction in duplicative tests and exams and overall improved outcomes at a reduced costs. In order for efforts to be successful, effective electronic clinical data exchange is necessary and this is currently a challenge between differing EMR systems, which requires further efforts in the future.
- Referring patients to specialists- Primary care physicians making medical decisions regarding when it is appropriate to refer a patient to a specialist, as well as decisions on which specialists to make the referral to is another key strategy. This is important in both small and large communities and will likely take on even greater importance in the future, as outcome data becomes increasingly available.
- Admitting patients for both acute and chronic care- Both primary care and specialist physicians will need to evaluate the decision to admit patients for both acute and for chronic care health issues. As the costs of inpatient and facility care tend to be much greater than care delivered in a physician office or outpatient settings, there are many

implications related to identifying actions that can be taken to work to prevent as many acute care episodes, as well as to carefully manage chronic conditions so that they do not become acute episodes that require more costly inpatient or facility health care.

Population health management will likely continue to take on increased importance as health care evolves. (Lewis).

### What Patients Want

In the midst of all of this change, one must pose the question, “What do patients want?”

There has been a growing trend of consumerism in health care and the patient’s changing perspective on preferred qualities and aspects of a physician and practice provided additional insight. The May 2016 issue of Consumer Reports posed the question, “What Makes a Great Doctor?” There were nine key factors cited:

Extended hours- The ability to get a medical appointment when a patient needs it and overall patient convenience and availability of care are valued by patients and also serve to decrease utilization of emergency rooms and urgent care centers by having physician office care available during evenings and weekends, not just Monday – Friday during business hours.

Sound judgment related to use of treatment choice and resources appropriate for the individual patient- Spending adequate time with each individual patient in order to understand the specific concerns and a tendency toward more conservative approaches such as use of physical therapy and medication first as opposed to quickly ordering an MRI and recommending surgery was cited.

Welcoming of complaints- Patient concerns identify areas that need improvement as well as lead to potential areas of new initiatives for future development.

Convenience and “one stop shopping- “Patients’ time is valuable and they appreciate a location where multiple services are available to minimize time and multiple trips to multiple locations and providers

Shared perspectives by primary care and specialist physicians on referrals and care - Established relationships and partnerships between primary care and specialist physicians foster coordination of care and seek to prevent duplication of tests and prescriptions.

Two-way communication- Active outreach to patients from the medical practice to follow up via phone calls, emails and follow up visits to ensure patients follow prescribe plan of care and mediations are being taken as prescribed. This also includes sharing of patient data between primary care and specialist physicians to ensure all parties involved in the circle of care are aware and up to date on what is happening with the patient.

Team approach to care- A shared mindset of the importance of team work at the practice that includes physicians, providers, and a supportive team of nurses, medical assistants, lab staff , medical records and administrative staff and the realization that the doctor cannot do it on his/her own was cited. A culture of team work with a focus on delivering high quality patient care and service was noted.

Fair work place- Hitting key metrics on quality and patient satisfaction rather than simply focusing on bottom line production that is used to reward physicians seems to result in a preferred model by patients.

Judicious use of resources and expense management- Responsible use of equipment and technology maximization of electronic medical records was also cited as a key factor.

All of the above are possible factors for consideration for small medical practices to evaluate and assess for implementation. (DeVita-Raeburn p. 34-36)

## Attributes of Successful Practices and Actions for Consideration

Private practices that wish to remain independent and financially and operationally viable must continuously monitor the changing health care environment and adjust their strategic plan and vision. The age demographics of the physician owners are one factor that impact the likelihood that a private practice will continue on. It has been shown that once physicians reach the age of 55, they become more likely to retire, become ill, and want to slow down or even experience a lack of interest in work. Private practice physician owners must have interest in the business side of medicine to help support the success of the practice and be involved. A shared vision for the practice that is clear and agreed upon by all partners is crucial for success. Data has shown that successful practices have high physician productivity, competitive physician compensation, and low turnover, experience growth in new patients, and have ancillary income beyond core services. Accounts receivables from payors and patient balances must be managed consistently and closely in order to maximize monthly collections. Low turnover of physicians and staff, and a culture of customer service for patients are also positive factors for long term viability. The position of the practice in the marketplace and the ability to recruit new physicians is also vital, as well as developing strategic alliances with local hospitals and other physician and health care partners in the community. Having shared strong leadership among multiple physician owners is also critical for a small medical practice to thrive for the long term. External factors like the number of competitors, the dynamics of the payors in the marketplace, and the amount of leverage and negotiating power that a practice has may also impact reimbursement and the opportunity for quality bonuses and incentive payments. Lastly, another key element is relationships with area hospitals and other physician partners in the community which impacts referral patterns. (Halley).

Practice managers should continually work to maximize the office and strengthen the revenue cycle and billing units. Another key focus should be keeping overhead and expenses down. It is

important to balance this focus with having enough staff in specific areas such as medical assistants, who can provide a 3:1 return on the cost to help physicians' productivity. Hiring and retention of the "right people" is also crucial to support the practice and minimize the high costs of employee turnover. Patient satisfaction needs to be measured and focused on continuous improvement. Having an effective patient portal and responding to patient calls and emails timely and accurately clearly impacts patient satisfaction. A comprehensive compliance plan that is continually assessing risks in the practice will support federal and state requirements. There are many organizations that can help support independent practices. ALLYNE Health is a consulting company that works to "save time, cut expenses and make dollars." A physician association such as the Association of Independent Doctors (AID) works to support the interests of independent physicians. There is also the Association of American Physicians and Surgeons (AAPS) which offers discounts on disability and other insurance products. Lastly, the personal focus of physicians' efforts to grow referrals in the community and working to foster positive work relationships with other providers is another area that needs ongoing support. ("Optimizing for an Independent Practice.").

#### Ability to Measure, Track, Improve and Report Quality Data

The potential role of the small medical practice in contributing to a reduction in health care costs and enhancing quality of care is significant. One key area is the ability to identify measure, track and report quality data. This data can demonstrate a physician's efforts to work to control hypertension, ensure preventative vaccinations are provided timely, work with patients to prevent unnecessary ER visits and hospital admissions and over time demonstrate a reduction in health care costs and higher quality. Physician determination to be successful in an independent practice requires much passion, as evidenced in the comments by Dominic Gaziano, MD, a solo internist practicing in Chicago. He stated that "I see other doctors selling their practices at an alarming rate, and I tell them, 'stick it out, you can do it yourself,' he says. "I truly believe independent

doctors can do more, by letting the patients be our masters and putting their interests first, and not a corporation or a hospital.” (Bendix)

#### Build on Current Practice Quality Initiatives and Work to Enhance

Collective recommendations encourage practices to start with the basics and build upon what data collection and reporting efforts, hopefully from an EMR, have already been implemented. This includes PQRS reporting, that practices may have been reporting for several years now, either through Part B claims submissions, or through a variety of channels with an EMR or a data registry vendor, or even a combination of both. One example is Amy Davis, DO, a solo practitioner specializing in palliative care in Philadelphia, who has been reporting PQRS data since 2012. This previous experience is very helpful, however Dr. Davis states that as related to MIPS, “... now that they’re developing the regulations, I’m trying to learn as much as I can as fast as I can.” In addition to PQRS reporting, another action to take now is for medical practices to review their Quality and Resource Use Reports (QRUR) that uses data from Medicare claims submissions to track cost and quality and benchmark this data across individuals and practices. These show performance and can potentially identify areas for improvement, despite the fact that the reports are quite complex and interpretation and analysis can be challenging depending on the capabilities of the reader. (Bendix).

#### Understand Efforts Vary Based on Practice Size

Different practices are taking on different strategies, often related to the practice size. Dr. Davis, as a solo practitioner, plans to continue reporting in the same categories she’s used for PQRS. Her goal in the first year or two of MIPS is to maintain her current level of Medicare reimbursement and not worry about trying to earn a bonus. “I think the initial goal for small practices needs to be, ‘how do we stay afloat?’” she says. “The way I’m looking to do that is to get credit for doing what I’m already doing. The overhead involved for the points that get you a

bonus is not cost-effective for a small practice like mine.” Larger practices that can afford the greater overhead costs, such as Gastrointestinal Specialists, a group of 22 physicians in central Virginia, has focused efforts over time to develop internal quality benchmarks based on their specialty and to exceed quality performance metrics across the board, to strive to exceed requirements and secure the highest level of bonus payments. “We’re not just thinking in terms of avoiding getting penalized or getting maybe a 1% bump,” he says. “We’re saying, ‘if we want to move the reimbursement needle, we need to do better than average consistently,’” states Lucien Roberts, administrator of Gastrointestinal Specialists, Inc. (Bendix).

#### Assess the Local Healthcare Environment for Opportunities with ACOs and CINs

Another strategy for consideration is to join an ACO and/or a clinically integrated network (CIN) to work with other medical groups to report data together and help mitigate the costs on any one group alone. Working together in a community can help to coordinate care and enhance communication in both medical practices and in local hospitals. An EMR is generally considered vital to do so in this model. Use of technology is a recurring theme, as it is necessary to maximize the use of the tools to be as efficient as possible and focus to maximize provider productivity and minimize provider time on administrative burdens as well as reduce the “number of clicks” in the EMR that a provider has to complete. Working to develop effective templates that can be used collaboratively with medical staff teams and physicians is one such practical approach that can contribute greatly. (Bendix).

#### Physician Leadership and Perspective Affects Practice Success

In the complex and rapidly changing health care environment, having a passion to remain independent and the determination to succeed in medicine also describe many physician practices. Rather than looking at the changes in a negative light, some physicians view the

changes as a new opportunity to gain even greater revenue over time and maintain autonomy and job satisfaction. For private practices, working toward value based care will entail multi-faceted strategies in order to remain independent and successful. Data is a recurring theme as the need for population health data analytics, care coordination and management, maximization of electronic health records and integration of this data across multiple platforms and health care providers and settings are crucial. Identification of high risk patients and working to develop a customized care plan for the patient who is engaged in their own health care is crucial. There are also new revenue opportunities through maximization of shared savings. (Tedeschi)

### Technology

Technology is another key area to be addressed. The use of technology by patients, by physicians, by practice staff and in interactions between a medical practice and other outside physicians, providers, hospitals and other health care organizations is a current and will continue to be a significant factor in the viability of small medical practices. Use of technology, automation and mobile tools to support physician productivity can distinguish successful medical practices. Technology is also highly relevant to meeting the requirements of federal, state and payor requirements to share patient health information and transfer updates and knowledge. (Chatham).

In terms of patients, the growth in the use of technology in our society is another area for success as now two thirds of Americans now use a smart phone. Use of mobile devices to help improve work flow including the use of iPads in the waiting rooms and offering free Wi-Fi to patients can help to decrease patient frustration related to wait time. Waiting room iPads can be used to provide patient education information to patients in the form of health education and disease specific articles and videos. A patient survey completed via a practice's iPad is another way to secure feedback on the patients' visit experience. (Chatham).

In terms of physicians and providers, the use of an iPad by a physician has multiple applications, including the ability to view patient charts, eprescribe medications, review previous existing patient notes, use keyboard shortcuts, EMR templates and voice recognition dictating systems to document patient visits. An iPad may assist a physician to make eye contact with the patient as an alternative to a desktop pc. Allowing a physician to be mobile and talk face to face with the patient through use of the iPad and a mobile EHR helps physicians to manage tasks and maximize productivity. (Chatham).

In terms of staff, if a medical practice has in-house billing and coding staff, the automation of billing procedures and denial management also greatly enhances monthly collections and maximization of reimbursement, while avoiding manual tasks. Fee schedules can be kept up to date to monitor for underpayments and payments can be posted electronically to support reduction of manual work. Collection of patient payments at the front desk and having a strong patient financial policy, as well as eligibility verification, collection of patient copays and deductibles and setting up monthly payment plans via an automated credit card on file can ensure steady income. (Chatham).

Still another consideration is the use of telemedicine or telehealth whereby a patient who is unable to travel to the practice, can use digital media to communicate with the physician for a consultation or to discuss a current problem. Insurance payors are starting to recognize this now as a billable service. This also may be of value for patients in rural areas where there is very limited access to physicians or for second opinions. Lastly, online awareness of a physician practice is crucial as more and more patients are searching on line for a physician or for answers to health issues. (Nelson et al 1-10).

## Electronic Medical Records and Evolving Tools

Implementation of one system that is integrated and can support all practice needs including billing, scheduling, clinical documentation and practice marketing that meets the needs of the unique practice is the ideal solution. Working to reduce and eliminate use of paper in the practice and eliminate manual tasks and save money can clearly be a benefit of EMR implementation.

KAREO, a cloud-based medical technology company, is one example of an organization that offers tools for independent practice. Practice reputation, awareness and overall marketing efforts of the practice necessitate the need for a having an effective web site. With the growth of technology and availability of mobile devices, many individuals use online resources to seek out medical services. Beyond this, depending on the comfort level of the physicians and practice resources available, there are many other actions that can be taken to manage online listings and generate positive patient reviews online. The patient may be viewed as a consumer in the health care market now and many value conveniences, access such as online scheduling and email and text reminders as well as patient portal. Patient surveys also help to confirm what specifics patients want. (How to Keep Your Name on the Door).

### Data and Benchmarking

KAREO has put forth specific recommendations that include the use of technologies that offer real time claim processing, and systems that automate dictation and support effective coding. Use of data to benchmark against peers and implementation of a practice dashboard to measure performance on an ongoing basis is a key recommendation. KAREO has suggested the following guidelines for medical practices to consider as goals to work toward industry standard best practices:

- Less than three days from time of service to claim submission

- Average days in account receivables is less than 40
- 85-90% of claims paid in 45 days or less
- No more than 15% of accounts receivable over 120 days
- Total unpaid claims less than 4% overall, meaning that 96% of claims submitted are paid and resolved fully
- Denial rate of 4% or less
- Net collection rate of 96% or better

(How to Keep Your Name on the Door). The above benchmarks are but one example, as many other organizations, such as MGMA, offer vast opportunities to share and gain access to medical practice data in order to assess and continuously improve.

Another EMR example is Athena Healthcare. In 2014, Athena noted the key challenges of the move from volume to value based care, complex government mandates, and an increase in the number of newly insured patients and growth in the volume of self pay patients that an independent practice would need to manage. Five key capabilities noted by Athena Healthcare are: strong financial performance, connectivity and clinical integration, ability to win at risk, competitive edge and adaptability to change. The most common definition of “independent” is “not subject to the control of others” according to Merriam-Webster dictionary and many physicians value the ability to practice medicine as they wish, to have control over the finances of their practice and to decide how to grow and provide care in the local health care market place. Increasing administrative burden is a challenge. For strong financial performance, practices need to be efficient and effective to submit claims, manage denials, collect and track payor and patient payments. Practices should work to maximize use of automation to decrease manual work and automate as many billing and revenue cycle functions as possible, as well as to ensure compliance with federal and state mandates related to reporting quality and cost data. Practices also need to manage patient scheduling and develop ways to measure financial performance and key

performance metrics. Care coordination integration and effective clinical health care data exchange is also crucial. (Five Essentials for Thriving and Surviving as an Independent Practice). It should be noted that selection of an EMR as well as creating a plan to partner with to maximize use and secure high value from a current EMR is dependent on the specific size, specialty, available resources and needs of each individual medical practice.

#### Evidence of the Value of Small and Physician Owned Practices

Three studies have been selected to review cost and quality outcomes data to examine the impact of small medical and physician owned medical practices on patients' health status.

#### Cost and Quality

In August 2013, a 20 percent random sample of nearly six million Medicare Part A and Part B patients were examined in a study entitled "Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries." The research examined quality results and overall health care spending for Medicare beneficiaries in 2009 and found that larger, hospital based medical practices had higher total Medicare beneficiary spending (\$849 higher), higher 30 day re-admission rates (+1.3% higher) and similar performance results on process measures of quality. Excluded from the study were long term nursing home residents and those who lived in an area of less than 2,500 residents where there was little provider integration. Medicare patients were attributed to the provider groups following the Medicare Shared Savings Program (MSSP) attribution model for the most allowed charges for primary care services. Health maintenance organization (HMO) market penetration rates were used to categorize the level of provider risk sharing. For costs, total spending in 2009 for Medicare Part A and Part B was tabulated. Quality of care results were measured utilizing the Healthcare Effectiveness Data and Information Set (HEDIS) and process quality of care measures including screening mammography, LDL cholesterol testing, hemoglobin A1C and evidence of a diabetic retinal exam. Results of the study

indicated that smaller, independent physician practices had lower per beneficiary spending where risk sharing was more common (-\$426). (McWilliams et al).

The study results indicated that spending was lower and quality of care was better for Medicare patients who were cared for by smaller, independent physician groups that had a strong primary care focus in which the providers accepted greater risk for the patient population. Differences in spending between larger and smaller groups was found, as the total per-beneficiary spending was \$849 higher for medium or large hospital based groups as compared to those for small physician groups. Spending included inpatient and outpatient care, including office visits, imaging, labs, cancer therapies and other Part B covered drugs. In terms of quality, the thirty day readmission rates were 1.3 percentage points higher for the hospital based groups. Further research is needed to continue to measure cost and quality results as health care models continue to evolve. (McWilliams et al).

In August 2014, the American Academy of Family Practice (AAFP) shared an article summary on the National Study of Small and Medium –Sized Practices (NSSMSP) conducted between July 2007 – March 2009 and examined hospital admission rates and the characteristics of the medical practices involved. In total there were 1,045 practices included. These ranged from physician owned, hospital owned and the practice size was categorized as small (1-2 physicians), medium (3-9 physicians) or large (10-19 physicians). The study reported that practices with one to two doctors had 33 percent less preventable hospital admissions, as compared to practices with ten to nineteen physicians, and twenty-seven percent fewer admissions as practices with three to nine physicians. The physician owned practices had a lower hospital admission rate (4.3 per hundred patients per year) as compared to the hospital-owned practices (6.4 per hundred patients). Andrew S. Ryan, Ph.D., MD stated that “The smaller practices in our sample, once we controlled for other characteristics, had significantly lower rates of ambulatory care-sensitive admissions.” This was surprising, as there has been a long standing belief that larger medical

practices delivered better health care, as there were more resources and staff available. There are a few hypotheses on why smaller practices had few hospital admissions. Some suggest that smaller practices have better relationships with patients and better access via patient phone calls and can provide direct support and input to avoid hospital admissions. This study may be of interest to insurance payors, as they typically do not focus on small practices but given the results, perhaps should further examine relationships with small practices and further assess the cost effective care that is being provided. The implications for this may be to provide more support for small practices, given the outcomes and results in cost savings and few hospital admissions. (Small Primary Care Practices Shine in National Study).

In October 2014, The Integrated Healthcare Association (IHA) in California conducted a three year study on commercial HMO members (this excluded elderly or indigent individuals) and examined total expenditures per patient in hospital-owned and physician owned physician organizations in the state of California from 2009 – 2012 on commercial HMO enrollees for professional, hospital, lab, pharmaceutical and ancillary services and showed that the hospital-owned physician organizations had higher incurred expenditures than the physician-owned organizations. As we have seen a trend in hospital and multi-hospital systems acquiring physician practices in an effort to integrate care, it is important to note that health care expenditures were greater in the hospital owned practices as opposed to the physician owned practices. The commercial HMO plans use a monthly per member per month payment model and financial bonuses were awarded based on performance on clinical process and outcomes, patient experience, patient satisfaction and use of clinical information systems as part of California's pay for performance system. Kaiser Foundation Health Plan was not included, as services are provided exclusively from the Kaiser Permanente medical groups. The study measured the possible linkage between hospital ownership and total expenditures on care. It is possible that local hospitals and multihospital systems may be able to better coordinate care, however

improvements were not seen in the area of lower expenses, but rather were 10% higher in the hospital owned organizations. (Robinson et al.). Ongoing tracking of health care expenses will continue to be a vital factor as health care evolves.

### Summary of Findings

In terms of summary of findings, it is clear that the rapid pace of change will continue in the American health care market. In order to be successful, small private medical practices must take action as the traditional modes of operation used in the past will likely not result in positive outcomes in our current health care environment. Practices must work to ensure financial strength and continually seek out expense reduction efforts. Practices must make a conscious effort to stay abreast of changes and to anticipate and embrace change. Small practices should consider pursuit of strategic partnerships (formal and informal) with other physicians, hospitals, health care facilities, insurance payors, and the community including assessment of possibly joining of an ACO and/or a CIN depending on what specific opportunities are available in the community in which the physician practice resides, as well as what may be the best fit for a given specialty. Continuous networking with other physicians, practice managers and hospital and integrated delivery organization constituents should also be considered to gain knowledge and understanding of the health care market. Having a focus on ongoing research, education and continuous improvement via local, state and national organizations such as MGMA, the AMA and local and state medical societies, and specialty societies are other helpful resources. Practices should consider a priority to develop a strong partnership with their electronic health record vendor if one is in place, or if not, to begin exploration rapidly, as the need for data appears to be paramount and likely will grow in the future. Lastly, working to complete both short and long term planning benefits the small, private medical practice with an operational plan as well as a strategic plan.

The significance of the findings are critical, given the key role that health care plays. Many have stated that if a person does not have their health, they do not have anything. Being healthy allows one to pursue goals and dreams as well as to help and care for others and make a contribution in society. In the United States, health care is valued and we have seen that with mandated coverage, it will continue to be a key element in our society.

#### What Other Practice Managers May Learn

In terms of what other practices managers may learn, it is evident that the work is extremely challenging and stimulating, while at the same time one will need perseverance and determination as well as an internal drive to continue to move forward to make progress and decisions in the best interest of the practice, physicians and staff. Collaboration among practice managers is vital so that each can help and support each other, and to promote continuous learning and improvement, with the bottom line mission to provide high quality and cost effective care.

#### Areas for Further Study

Areas for further study should focus based on the final MACRA rule, to measure the impact on the small medical practice, as well as to continue to examine the cost and quality outcomes of small and large practices, and hospital and physician owned practices variations, in an effort to identify best practices that can be replicated to serve all patients. Further study in the area of cost and quality outcomes in small physician owned practices, hospital owned practices, and larger single and multi-specialty practices should be examined in future years.

#### Lessons Learned

In terms of lessons learned, small medical practices and physicians must be aware and remain vigilant in the evolving American health care system. While managing and responding to change can be difficult, responding with strength and determination to be successful can be extremely

rewarding and can give a practice manager an intrinsic feeling of personal accomplishment and achievement that one has been able to make a difference in the lives of patients, physicians, staff and other constituents.

## Conclusion

It is clear that health care in the United States has undergone change at rapid pace and continuous change is expected. Small private practices have served as a strong foundation of the health care system. Despite the rapid and expected rate of change in the American health care system, it is possible that the small medical practice will not only survive, but will thrive. Further study is warranted post the November 2016 election and final CMS rules on MACRA and MIPS.

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