Owning a primary care practice has rarely—if ever—been more challenging than it is today. From stagnating reimbursements to conflicting government mandates to evolving technologies, sometimes the odds against success—and the temptation to leave independent practice and work for someone else—can seem overwhelming.

Fortunately, it doesn’t have to be that way. In this and the following issue of Medical Economics, we present physicians and practices that are beating the odds by fighting back. They are overcoming the obstacles to success and practicing medicine the way they want to. We hope their examples inspire you to fight back too.
Owning and Operating an independent medical practice has never been easy, but in the last decade or so the number and complexity of the challenges have grown exponentially.

Between mandates for tracking and reporting quality data, the growing shift towards value-based payment models, the need to stay abreast of new technologies, growing competition from new types of providers such as walk-in clinics, and reimbursement levels not keeping up with operating costs, the obstacles to keeping a practice afloat can seem insurmountable.

Little wonder, then, that the percentage of physicians describing themselves as independent practice owners decreased from 62% in 2008 to 35% in 2013, according to the 2014 Physicians Foundation Survey of American Physicians. In addition, the survey found that 53% of doctors now describe themselves as hospital or medical group employees, compared with 38% in 2008.

So are independent practitioners doomed? If you own a practice, should you take the next buy-out offer from your local hospital system? Not at all. In fact, practices all over the country are finding ways to survive, and even thrive, amid the changes roiling the medical industry.

As part of our ongoing “Fighting Back” series, Medical Economics asked physicians and practice administrators to share their strategies for overcoming the challenges facing independent practices while continuing to provide excellent patient care.

Their advice:

- accept that electronic health records (EHRs) are necessary to function in today’s healthcare environment and use them to improve patient care by, for example, tracking whether patients have gotten screenings or tests you have recommended previously;
- look for ways to differentiate your practice in the eyes of payers in terms of the services you provide, or your efficiency and outcomes;
- make population health management part of your care (and business) strategy by developing patient registries and tracking quality data;
- embrace government reporting mandates and use them as opportunities to see where you can improve patient care.

Achieving many of these goals requires

JOINING FORCES
The benefits of forming business alliances with other small practices

There are many ways of joining forces with other independent physicians, from buying consortiums and independent physician associations to creating formal business alliances with other practices. Here are some of the potential benefits of joining forces:

<table>
<thead>
<tr>
<th>Size</th>
<th>Expanded group size, thereby gaining significant market exposure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracting</td>
<td>Payer contract negotiation clout.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Physician autonomy in clinical practice and decision-making.</td>
</tr>
<tr>
<td>Governance</td>
<td>Physician governance, often with equal representation on the governing body.</td>
</tr>
<tr>
<td>Ownership</td>
<td>Physician ownership and continuation of private practice.</td>
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<tr>
<td>Shared Costs</td>
<td>Shared cost of practice (overhead) expenditures, such as accounts receivable management, legal/accounting, group purchasing, information technology, and management services—operational, financial, human resources, and facility.</td>
</tr>
<tr>
<td>Shared Facilities</td>
<td>Consolidated practice site cost vs. numerous small office rents.</td>
</tr>
<tr>
<td>On-call</td>
<td>Shared on-call coverage leading to improved work/life balance.</td>
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</tbody>
</table>

Sources: Deborah Walker Keegen, PhD, FACMPE, and Marshall M. Baker, MS, PACMPE
Fighting back, part 1

more heft, in terms of patient numbers and financial clout, than most small practices can muster by themselves. Accordingly, experts say, staying independent likely requires teaming up with other independent practices through vehicles such as accountable care organizations (ACOs) and independent practice associations (IPAs).

While some of these recommendations may be difficult to implement, they can bring major returns in terms of better outcomes for patients and increased satisfaction for you and your staff, says Nitin Damle, MD, FACP, an internist in Wakefield, Rhode Island and president-elect of the American College of Physicians.

“I think once you recognize that this new direction really has value, you can jump on board, and in the end you’ll feel like your life and your professional satisfaction will be improved because you’ll see that you’re taking better care of patients and are able to spend more time with them,” Damle says.

NEGOTIATING WITH PAYERS

Of course, enjoying the benefits of independent practice depends on being able to pay yourself and your staff and meet overhead expenses.

And doing that depends to a large extent on your practice’s ability to negotiate advantageous contracts with commercial payers.

For Lucien Roberts III, MHA, FACPME, successful negotiations with payers comes down to two things: relationships and preparation. As administrator of a Richmond, Virginia gastrointestinal practice, Roberts has negotiated contracts that resulted in substantial multiples of what Medicare pays with many of the major commercial payers in the country, including Horizon, Aetna, Cigna, and UnitedHealthcare. He says he makes a point of touching base with representatives of his major payers every three months.

“I found it’s a lot more effective to negotiate with someone you have a relationship with than being a stranger coming in with a demand for more pay,” he says. “Even if all they do is say ‘everything’s fine with your practice,’ when it comes time to talk about a new contract you can say ‘look, we’ve been talking for two years and you’ve said things are fine here. It takes the element of surprise off the table.’”

In terms of preparation, Roberts says it’s vital to differentiate your practice from your competitors and make it important in the eyes of payers. “You’re a little fish in a big ocean and you need to get their attention. Maybe you’re the only practice in your part of town, or you cover a facility that one else does. What can you do to gain leverage?”

Like most practices, Roberts relies on measurements of cost, efficiency and outcomes to compare his practice with competitors and demonstrate its value to a payer. For primary care practices, he points out, such comparisons can be helpful for comparing evaluation and management coding.

“If you’re not abusing level 5 visits you can point out that you’re not overcoding. Because if someone is at the high end then they’re probably already getting a premium in the payer’s eyes,” he says. Similarly with prior authorizations—if you can show a payer that your practice orders fewer expensive procedures than similar practices you may be able to bypass, or at least expedite, that...
Fighting back, part 1

PAYER REPORT CARD

Lucien Roberts III, MHA, FACMPE, a practice administrator in Richmond, Virginia, asks his staff to fill out the follow report card to evaluate payers.

Please grade all payers on a scale of ‘A’ to ‘F’, with ‘A’ being wonderful. The grades are not exclusive; more than one payer can receive the same grade. Please share comments as to why a payer is pleasant or painful to work with, in your opinion. If a payer employee/MD is helpful or helpless, include their name with your comments please.

<table>
<thead>
<tr>
<th>Payor</th>
<th>Grade</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer A</td>
<td>B-</td>
<td>Inconsistent authorization turnaround (sometimes same day, sometimes 3 days), but otherwise okay. Patients get mad at us for Payer A’s faults!</td>
</tr>
<tr>
<td>Payer B</td>
<td>D</td>
<td>Slowest payer; ‘loses’ claims all the time; do not respond to appeal requests unless we bug them. 34% of our Payer B accounts receivable is over 90 days.</td>
</tr>
<tr>
<td>Payer C</td>
<td>A</td>
<td>Very easy to work with! They pay quickly and correctly.</td>
</tr>
<tr>
<td>Payer D</td>
<td>C</td>
<td>Very hard to reach anyone in Customer Service, and when we do, we get different answers from different people.</td>
</tr>
<tr>
<td>Payer X</td>
<td>C-</td>
<td>Do not pay well given the hoops we must jump through. They have the County insurance contract, and three County leaders are our loyal pts.</td>
</tr>
<tr>
<td>Payer Y</td>
<td>B</td>
<td>No problems, except “Dr. Denial” gives the docs fits.</td>
</tr>
</tbody>
</table>

Payer’s authorization process.

Sometimes, Roberts adds, finding negotiating leverage requires looking beyond practice metrics. “I like to find out if the payer has any employees are patients of ours,” he says. “If I tell the person I’m negotiating with, gosh, we have 30 of your employees as patients here, that really resonates.”

With the growth of value-based payment models, payers today are more willing to treat providers as partners in the drive to contain costs and improve quality, says Al Kurose, MD, MBA. Kurose is chief executive officer of Coastal Medical, a primary care-driven ACO in Rhode Island with 117 providers and about 120,000 patients. When he became CEO in 2008, he says, contracts were largely fee-for-service, and negotiations with payers consisted of “one side coming in high, one side low, and you met in the middle.”

Today, he says, the picture is different. “Now we’re partners with the payers in terms of population health management, working together in pursuit of the triple aim for a shared population of members. It’s much more collaborative.”

To succeed in this new environment, both sides need to understand the needs of those sitting across the table, Kurose says. “When we start on a new contracting cycle we begin with input from both sides, so each understand the other’s strategic priorities.
because the process is more complicated than a simple dollars-and-cents fee schedule and sometimes the shared objectives take time to work out.”

Kurose cites the example of negotiating a shared savings contract based on total cost of care. “How does quality influence shared savings? What are the reporting responsibilities going to be, and how will targets be set? Can we get help funding positions for team-based care, like a nurse care manager? There can be a lot of different moving parts to the process,” he says.

Kurose emphasizes that developing a collaborative relationship with payers usually requires a larger patient population than most small practices can deliver—hence the importance of joining forces with others through an ACO or IPA. “With any given payer, you need to have a shared population of sufficient size for it to have statistical validity for doing population-based cost performance in these new payment models,” he says.

**Electronic Health Records**

For all their headaches and expense, electronic health records (EHRs) can be another weapon in the fight to stay independent, provided you’re willing to use the technology to its fullest extent and undertake the changes in workflow and practice culture that EHRs require to be effective.

“We can either fight it [the technology] or figure out how to use it and look for its benefits,” says Chris Apostol, DO, an internist in a seven-provider practice in Augusta, Georgia. The ability to capture all of a patient’s pertinent data in a single screen has made it easier to track care and input data from other sources, such as Georgia’s immunization registry.

The introduction of EHRs also has led to greater standardization of patient encounters among providers in the practice, thereby improving the practice’s efficiency, Apostol says. “No matter who is seeing the patient, the encounters now look pretty much the same, because the same quality measures are going to be met and the same information is going in the same spots. It makes for a much smoother workflow,” he says.

The availability of services such as electronic appointments and prescription refills through the system’s patient portal has freed up staff members’ time to focus on other tasks, such as making sure that patients followed through on their referrals or quality data reporting.

For Apostol, one of the chief benefits of EHRs has been to make the time spent with patients more meaningful, because all the information he needs—including reports from specialists—is available at his fingertips. “It allows me to understand the patient and what’s been going on with all their care, rather than here’s my episode, I see them again in six months, and I have to take their word for everything that happens in between,” he says.

EHRs also make it possible for practices to collect and generate the data needed for population health—a requirement for many of the value-based payment models, notes Yul Ejnes, MD, MACP, a practitioner with Coastal Medical. He cites the example of screenings. Previously, when he or his colleagues ordered a test such as a colonoscopy, they wouldn’t know if the patient had received the procedure until the next time they saw him.

“Now we’re able to track these things on a practice-wide basis,” he says. “Often we find the patient ran
Evolving Practice Models

The changes overtaking healthcare delivery are putting an end to the era of the small practice operating in isolation. Increasingly, practices are finding that their survival depends on working with others to obtain the resources they need to stay afloat.

But that raises the question: How do you become part of a larger group without sacrificing your independence? For some, the answer lies in models such as the accountable care organization (ACO). Others are finding their own paths.

Robert Eidus, MD, MBA, a family physician in Cranford, New Jersey, falls into the latter category. He has found that sweet spot of obtaining the benefits of size while maintaining his practice’s autonomy. The process began in 2011 when, after nine years in solo practice, “I realized that being a small independent practice was not sustainable in the long run because of the administrative complexity,” he says. (As a solo practitioner he was the first in New Jersey to obtain patient-centered medical home certification.)

In addition, “the likelihood of transitioning from paying for volume to paying for value meant I was going to need the resources to measure statistics better.” His solution was to join with other providers to form Vanguard Medical Group, consisting of six sites and 32 primary care practitioners caring for about 60,000 active lives. Eidus is president of the group.

Operating under a single tax ID number, Vanguard’s practices have been able to centralize administrative functions including human resources, accounting, and billing, and patient databases. The latter allows Vanguard to do quality management and reporting.

“We’re trying to get the best of both worlds—having healthcare be small and local while on the other hand off-loading administrative complexities and getting better negotiated deals with payers.

“You’re not going to get far with payers if you don’t understand what value you can present,” he adds. “When we went to payers we got a better deal because we had several years of performance data we could show them, and could say ‘we’re a high-performing practice and we’d like to be compensated accordingly.’” That approach earned them better compensation rates and care coordination fees from two major commercial payers.

Eidus says Vanguard regularly gets buyout offers from integrated healthcare networks, and while some are tempting, they’ve turned them all down.

“We’re always being told, ‘you’re too small, you don’t have access to capital, you need to join one of these behemoth organizations,’” he says. “We may not get all the benefits as if we were part of one of those large systems, but on the other hand we don’t have all the encumbrances. We’re glad to collaborate with them, we just don’t want to be employed by them.”

COMING AUGUST 25

Fighting back, part 2

How some physicians have managed to maintain their independence, despite the challenges