As practices continue to deal with declining reimbursement, federal and commercial payers are exploring new payment models. Here's how to prepare and respond.

After years of declining reimbursement, it should come as no shock that the results of our 2011 Fee Schedule Survey are less than appealing. But you may be surprised by what we tell you to do about it — and what we tell you not to do about it.

Here's a hint: We're not going to tell you to focus as much on the typical reimbursement negotiations with payers — those conversations probably won't get you as far as they once did. But it's not all bad news. The reimbursement model is changing, and as a result, the opportunity to have a new type of conversation with payers is emerging.

"Nowadays, it's not so much about a negotiation on fees, it's a negotiation about how providers and insurers can partner-up to deliver greater value to patients," says Susanne Madden, president of medical practice consulting company The Verden Group.

But before we get to that, let's rip off the Band-Aid. Here's an overview of what you're experiencing right now when it comes to reimbursements.

* Check out our slide show to view commercial payer reimbursement data for nearly 900 primary-care physicians and specialists.

**Physicians hit hard**
This year, average commercial payer reimbursements for new and established office visits dropped 2.86 percent. That's something Madden says matches up with what her clients are experiencing and what she expects they will continue experiencing in the future.

It's "absolutely a trend" she says. "We are seeing fee schedule cuts just really rolling through quarter after quarter, quite frankly. It's not even a matter of a fee schedule change once a year or every couple of years now."

Here's some more of the findings from our survey:

The most frequently billed code for family medicine, pediatrics, and internal medicine — longer, established-patient visit 99214 — dropped about 1 percent to $91.67; longer, new-patient visit 99204 fell a whopping 5.87 percent to $123.66; and shorter established-patient visit 99211 had the largest increase of all new and established patient visits — a boost of only 3 percent.

We first noted in 2009 that Medicare, once the reimbursement floor that commercial payers built on, was starting to become the ceiling. It seems that shift is now complete. In 2011, Medicare paid more than commercial payers for all office visits except for shorter visits 99201, 99211, and 99212. Overall, Medicare reimbursements increased an average 2.3 percent, that's on top of a 7.4 percent increase experienced last year.

Attorney Richard Wagner, managing director of Chicago-based Wagner Healthcare Consulting, LLC, says the government has been under "a lot of pressure" to maintain Medicare's reimbursement rates. But he cautions, "I think we could almost bank on the fact that CMS is not going to be increasing those payments at a steady rate anymore."

**Not budging**
Troy Morris, a family physician based in Southaven, Miss., is among the group of physicians hit hardest with lower reimbursements: those working in small and solo practices.

"As far as private payers, we've seen no increases in reimbursements," Morris, who operates a two-physician practice, says. "The private payers won't even come to the table anymore and negotiate with us."

Morris is not alone, according to Greg Mertz, senior project manager at consulting company Healthcare Strategy Group. "I don't see virtually anybody being successful negotiating increases with commercial carriers unless they're truly either a market leader or in a somewhat isolated area," he says. "Typically these days, payers are just digging in their heels and just basically saying, take it or leave it."
Spring Hill, Fla.-based family physician Karl Leibensperger stopped practicing medicine seven years ago to become practice administrator at his wife's OB/GYN practice. He says practices in his area are also experiencing the "downward push" from payers. He suspects it's become so bad for some physicians that they are retiring earlier than anticipated. "We live in an area with older doctors who are on the edge of retirement, and we've seen one retire entirely, one announce his retirement and then rescind it, one give up within the past six months," Leibensperger says. Clearly these are trying times for physicians. But as the door to negotiations closes, another door is opening.

**Value vs. volume**

Despite the struggles his fellow physicians are facing, Leibensperger has kept his office thriving and the reimbursements flowing. One reason for that, he says, is that he saves payers money — and he makes sure they know it. "They're always looking for savings to decrease their bottom line," he says. "We keep track of things so that we don't have to run a test 'just because,' and by doing that we keep their costs down." Leibensperger is right on track toward not only keeping his reimbursements steady but also having the opportunity to participate in a new type of conversation with payers.

"What we're seeing right now [are] a lot of initiatives coming out of Washington, especially with healthcare reform, with this emphasis on value over volume," Wagner says. "You saw it with ACOs, you're seeing it with the pioneer program, and now bundled payments." And he predicts the commercial payers will begin implementing similar programs.

Some already are, says Madden. Often, she says, if a practice is able to keep costs down (and prove that to the payer, as Leibensperger does) there is willingness on the payers' end to share that savings. "Where we are gaining traction is looking at more creative ways of financing, such as pay-for-performance or bonuses for certain targets being met, but it basically is all around this idea of cost-sharing between the insurance company and the provider," Madden says.

As a result, when asking for higher or additional reimbursements, practices should frame the conversation around "value," she says. In other words, they need to prove to the payer that they are lowering cost while improving quality of care.

When approaching payers, she says, practices should ask: "What are you doing in the area of pay-for-performance, what sort of value-based initiatives are you looking to fund, and how can we go about partnering up?"

**Here to stay**

Like many physicians, Morris, the Mississippi-based family physician, is skeptical that physicians will actually be paid — and paid fairly — for quality and savings. "Are [reimbursements] really going to change? Is it really going to work?" he asks. "It's one of those things that I'll believe it when I see it."

Still, for eight years, Morris' practice has participated in a clinical quality improvement program. "I try to be proactive and look at what's coming down the pike and prepare as best we can," he says. Being prepared is a smart move, says Elizabeth Woodcock, consultant and founder of practice management company Woodcock & Associates. "In my opinion, you shouldn't have your head in the sand and not pay any attention," she says. Still, it's understandable that physicians are responding to the changes with trepidation, she says. "Even though we've talked about this pay-for-performance, pay-for-quality for years and years and years, it simply hasn't come to fruition."

But as U.S. healthcare spending reaches an all-time high, changes to the physician reimbursement model are becoming unavoidable, Mertz says. "Medicare and Medicaid are not sustainable in their current format," he says. As a result, the government has sought to prove (and has proved) through pilot and demonstration programs that physicians can reduce the cost of care when given incentives to do so, Mertz says. "That's where healthcare reimbursement is going," he says. "Anybody that assumes the next five years is going to be business as usual is at risk for a very bad lesson in failure."

Wagner also predicts that this time the reimbursement changes are real, and they are very likely to catch on full throttle within the next five to 10 years. "It's not a matter of if, it's when," he says. "...I think fee-for-service has an expiration date, and it's going to hit us sooner than we think."

**Prepping for change**

Although commercial payers are at varying stages of implementing new reimbursement models, it's easy to see where such initiatives are headed: incentives and higher pay rates for practices that prove they are providing low-cost quality care. To ensure that your practice is situated well for the future, prepared for new reimbursement opportunities, and equipped with negotiating leverage, here are a few key things to focus on:

• **Best Practices.** If your practice has a clinical quality program, if it's actually tracking outcomes, if
it's following evidence-based medicine, Madden says, the insurance companies really want to talk to you. If not, don't even bother contacting the payers. "You're not doing anything that's improving anything so why should they pay you any more for the same old same old?" she asks. "It's just not going to happen anymore."

If your practice is working from the ground up when it comes to implementing these programs and policies, a great place to start is by contacting your medical specialty society or association. Often it can provide advice, guidance, and templates for your practice to follow, she says.

• **Data. Data. Data.** To take full advantage of shifting reimbursement programs, practices need to "take it up to a whole other level when it comes to [their] own data," Woodcock says. Compiling your own data will help you analyze your own patient populations, and that will help you prove to the payers that you are providing higher quality at lower cost than most other practices. High-performing practices will have "moved from just understanding their reimbursements to truly understanding and being able to prove the quality of care they're providing," Woodcock says.

• **EHRs.** Without the right technical infrastructure through which to report data, Wagner says, payers aren't likely to allow you to participate in new reimbursement programs. An EHR is essential because it will allow you and the payers to measure your performance and analyze your data effectively and easily.

"You can't just hand in a three-hole-punch notebook and expect your payment," Wagner says. "In order to participate in so many of these programs coming out of health reform ... you need to have those [reliable EHR] systems in place."

• **Communicate.** Physicians not only need to understand these new reimbursement opportunities, they also need to communicate effectively with hospitals about these programs. That's because many of them rely on a coordinated approach to patient care with the idea that improved quality and reduced cost will come with increased integration between treatment centers.

As a result, practices and hospitals will need to work together to determine how to streamline the care process, how to control costs, and how to improve patient care, Mertz says. "If that doesn't start soon, [practices] will be behind the curve, reimbursement will change, and they'll be playing catch-up at their financial disadvantage."{C}

It sounds like a lot of work, and it is. But don't be overwhelmed — you can start small. Madden suggests practices take one element of their patient population, say the diabetics, and track those patients for 90 days. Log every time they come in for a visit; log the care and treatment they receive. Pretty soon, she says, it will become clear if your practice is following the proper guidelines and what your practice needs to improve upon.

**The good news**

Despite the headaches, stress, and frustration that come with this shift towards value over volume reimbursements — that it's one more thing on a constantly growing list of things for physicians to worry about — the shift might actually be a good thing for physicians. Without it, Mertz says, reimbursements will continue decreasing because the money to increase those rates is no longer available. "The only way that [practices are] going to win financially is responding aggressively to these incentives," he says. "If in fact they decide they're going to maintain their fee-for-service world until it just goes away, they're going to see what we're seeing now. No increases." At least new reimbursement models have the potential to bring about new reimbursement opportunities for physicians, he says.

In addition, in an ideal world physicians would be paid for quality of care rather than the amount of services they provide. New reimbursement models have the potential to bring physicians back to practicing great quality medicine — and being paid for it.

"If we could get a type of a payment system that incentivizes saving patients' lives and making them as good as possible, in as little time as possible, with as little cost as possible ... everyone benefits," Wagner says. "So the government realizes it, private payers realize it, it's just a question of moving from the one main reimbursement system we have now to something that is sustainable."

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**In Summary**

To take advantage of new reimbursement incentives and models:

• Follow evidence-based practice guidelines
• Track, analyze, and compile patient population data
• Use EHRs aggressively
• Work together with hospitals to streamline the care process and control costs
• Ask payers about pay-for-performance programs; value-based initiatives; and opportunities to
create partnerships
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