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### Labor Day break

*Part B News* will take its scheduled break next week. Our next issue will be dated Sept. 10, 2018. In the meantime, stay tuned to the *Part B News* Blog at <https://pbn.decisionhealth.com/Blogs/default.aspx> for news updates. Best wishes for a safe and happy holiday from Karen, Roy and Richard.

*All Medicare fees are par, office, national unless otherwise noted.*

### Physician payments

## View a patient's pic? Under CMS proposal, you can get paid for that

CMS is amping up its tech-based coverage policies, and you'll find a suite of new ways — assessing images, taking phone calls and more — to get paid in 2019 should the proposals get finalized. However, experts caution that some of the glitter may fade when you dive into the details of the services.

With the proposed 2019 Medicare physician fee schedule, CMS seeks to push the envelope on virtual and video-based care. The proposals amount to the agency “trying to find creative workarounds” for the limitations imposed on it by Congress, says Melissa Goldman, attorney with Baker (see *Physician payments*, p. 6)

### Patient encounters

## Losing touch with patients as you grow? Try these high-touch tricks to reconnect

A study suggests large practices actually underperform small practices in cost of care and hospital readmissions, but you might redress the balance by engaging independent networks, educating your patients and using your imagination.

A paper in the July 5 issue of *Health Services Research* describes a study in which the authors correlated survey results from 1,040 practices with Medicare data to compare care results of “high-need” patients — those with two or more “frailties” such as fatigue, low appetite and weakness — between small (see *Patient encounters*, p. 7)

### Dominate your denials, improve cash flow



By understanding the hundreds of claim adjustment reason codes (CARC), remittance advice remark codes (RARC) and other denial codes that can accompany a denied medical claim, you can avoid lost money and disrupted workflow. Get an action plan during the webinar **Decipher Denial Codes: Waste Less Time, Get Back More Denied Reimbursement** on Sept. 18. Learn more: [www.codingbooks.com/YMPDA091818](http://www.codingbooks.com/YMPDA091818).

## Regulatory update

## Supreme Court nominee likely pro-business, skeptical of government

With the upcoming vetting of Brett Kavanaugh for the soon-to-be vacant seat of Justice Anthony Kennedy on the U.S. Supreme Court, providers may see a pro-business ally whose past rulings show a skepticism of the power of administrative agencies.

Kavanaugh has shown concern that administrative agencies receive too much judicial deference, says attorney Robert Markette of Indianapolis-based firm Hall, Render, Killian, Heath & Lyman. In other words, rulings in Kavanaugh's court have shown an unwillingness to simply let administrative agencies to do whatever they want — Kavanaugh holds them accountable to the letter of the law.

For example, in Kavanaugh's 2017 dissent in *United States Telecom Association v. Federal Communications Commission* that requested a rehearing of the decision upholding the commission's net neutrality rule, he noted that Congress didn't authorize the commission to issue the rule. He further argued that the Supreme Court "has required clear congressional authorization for major agency rules" and that an agency wanting to exercise "expansive regulatory authority" must have clear authorization from Congress "to take such a major regulatory action."

That's good for providers considering the regulatory burden administrative bodies such as CMS place on them, Markette says.

"A lot of the courts have become too comfortable with deferring to administrative agencies," he says. "Hopefully what we're going to see with a Supreme Court with Kavanaugh is a narrowing or elimination of the deference administrative agencies receive and an expansion of the courts' power to review agency decision-making."

Mike King, a shareholder in the Denver office of Brownstein Hyatt Farber Schreck, LLP, agrees that Kavanaugh is likely to take a "less expansive view of the legitimacy of government" agencies to overreach their authority.

## Court has more major issues coming

In the next few terms, the court may tackle issues related to the False Claims Act (FCA). Several lower courts are challenging aspects of the case, including the statute of limitations for FCA claims and the level of proof needed to prove falsity.

In the latter case, *Davis v. GGNHC Administrative Services*, more commonly known as the AseraCare case, the 11th Circuit Court of Appeals is expected to hand down a decision soon as to whether the medical opinions of dueling experts in Medicare cases may be considered objectively false under the FCA.

Markette says several cases involving expert testimony and physician opinions of medical necessity — including AseraCare — are in the circuit courts right now and could work their way up to the Supreme Court.

He is also optimistic that a Supreme Court with Kavanaugh could lead to more pressure on CMS to fix the

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broken appeals system, which would result in a fairer timeline for providers regarding Medicare audits and appeals.

Kavanaugh's confirmation to the high court could also have an effect on the future of the Affordable Care Act (ACA). When the Supreme Court upheld the ACA and its power to tax, Chief Justice John Roberts had left-leaning votes including Justices Stephen Breyer and Ruth Bader Ginsberg in the 5-4 decision. If they leave the court, King sees the ACA being challenged on constitutional grounds and the popular components of the act being dismantled by a conservative Supreme Court.

### Kavanaugh's background

Since 2006, Kavanaugh has sat on the D.C. Circuit Court of Appeals. Prior to that appointment, he took part in some of the most momentous events of the late 1990s and early 2000s.

Kavanaugh worked as an attorney for Kenneth Starr during the investigation of President Bill Clinton prior to his impeachment by the House in 1998, and later served on the legal team for Elian Gonzalez, the child who came to South Florida and was returned to his father in Cuba in 2000.

Kavanaugh worked for President George W. Bush during the Gore-Bush election recount and later joined the president's staff before being nominated to the D.C. Circuit Court.

King expects Kavanaugh to be confirmed. He sees more significant changes being made to the court in the coming years because of the age of liberal-leaning justices including Ginsberg and Breyer.

"There's going to be more retirements; the court is going to be further reshaped, and it could lead to some much more dramatic votes," King says. — *Angela Childers* ([angela.childers@gmail.com](mailto:angela.childers@gmail.com))

### Accountable care organizations

## Nowhere to hide: Proposed rule kills risk-free path to shared savings

A proposed Shared Savings rule pushes risk onto all participants within a few years and signals more risk in the future for all Medicare providers as well.

CMS published its "Pathways to Success" proposed rule for the Shared Savings program Aug. 17. The 607-page rule was summarized by CMS Administrator Seema Verma in an Aug. 9 *Health Affairs* article.

The Medicare Shared Savings Program (MSSP) is CMS' primary accountable care organization (ACO) program, launched in April 2012 with 27 participants and currently comprising 561 organizations covering 10.5 million Medicare beneficiaries (*PBN 4/11/12*). Over its first three years of operation, the program was reported to have "reduced [Medicare] spending by \$3.4 billion" based on expected Medicare expenditures for a net spending reduction of nearly \$1 billion and to have "generally improved the quality of care [participating organizations] provided," according to the Office of Inspector General (OIG) in 2017. Shared Savings ACOs earned \$1.3 billion in shared savings payments in those three years.

But the program is top-heavy in terms of who's doing the saving: OIG reported in 2017 that about a third of MSSP participants were not saving money, while about half of spending reduction over the first three years was "generated by just 36 ACOs. Three ACOs in that group generated a quarter of that amount." And an independent analysis appearing in November 2017 at *Health Affairs* showed the program losing money in 2016: "After bonus payments were paid, Medicare saw a net loss of \$39 million, representing 0.05 percent of program costs for the MSSP in 2016."

Observers blame MSSP participants that take on little or no downside risk. In its June report on Medicare ACOs, the Medicare Payment Advisory Commission (MedPAC) talked about how "asymmetric" ACO tracks that offer providers "greater opportunities for savings than losses ... could result in a cost for the Medicare program" as opposed to the intended savings. And in a May 7 address to the American Hospital Association's Annual Membership Meeting, Verma said in as many words, "these ACOs are actually increasing Medicare spending."

CMS has had trouble moving MSSP participants from Shared Savings' Track 1 path — which lets them earn rewards if they meet savings benchmarks without having to pay money if they don't, also known as "one-sided" risk — to its Track 2 and Track 3 paths, which are "two-sided" risk models that do require participants to pay for missing benchmarks (*PBN 4/12/18*). This year, CMS even added a Track 1+ model with limited downside risk to lure Track 1 participants in the direction of two-sided risk.

### Eliminating tracks, introducing new models

In *Health Affairs*, Verma called the current arrangement by which Track 1 participants can avoid risk for an entire six-year contract "unacceptable." The rule proposes to do away with the current Tracks 1, 1+, 2 and 3 and have just "basic" and "enhanced" tracks. All participants would start

in a five-year basic contract. The maximum number of years a participant could have no-downside membership would be cut to two years and any previous Shared Savings members would get just one.

Upshot: All participants would experience at least three years of two-sided risk, with the amount of possible shared savings gains based on quality performance going up year by year, at least at first, and possible losses also growing, though at a more gradual rate.

After one basic contract term, some basic entrants would be permitted to sign up for another five years on the basic track (at its highest, fifth-year level of risk), but “high revenue” participants would be sent on to the enhanced track with higher risk-reward. High-revenue ACOs, as CMS proposes, would “typically include a hospital billing through an ACO participant TIN [tax identification number], [organizations that] are generally more capable of accepting higher risk” than low-revenue ACOs. High-revenue ACOs would be allowed to choose to start with the enhanced track.

A start date for the new contracts of July 1, 2019, is proposed; the next contract cycle for new entrants would begin Jan. 1, 2020.

### ‘Incentives’ for patients

CMS is also slightly changing beneficiary assignment for Shared Savings ACOs. Previously, patients were assigned based on the volume of the services the ACO supplied to them; in the 2017 Medicare physician fee schedule, CMS instituted a voluntary alignment process in which beneficiaries got a yearly chance to affiliate with an ACO if they had seen one of its providers at least once in the calendar year (*PBN 11/14/16*). Under the proposed rule, beneficiaries would receive an enrollment letter from the ACO offering them the option to align.

Also under the proposed rule, ACOs would be permitted to tempt beneficiaries with “incentive payments” worth up to \$20 for each service the ACO renders them. CMS would also issue “limited waivers of the originating site and geographic requirements” on some covered telehealth services for ACO beneficiaries.

There are also changes proposed for the benchmarking that determines whether MSSP ACOs get a bonus or a penalty. Previously, new entrants were benchmarked against their own historical performance for up to three years, after which they were judged by a historical/regional FFS hybrid benchmark; under this rule, they would be compared more directly with regional FFS rates.

### Exit strategy?

There’s some good news for first-time risk-takers: From their first year of two-sided risk, entrants will be eligible to become advanced alternative payment models (APMs) for Quality Payment Program (QPP) purposes — meaning they can abandon the Merit-based Incentive Payment System (MIPS).

But many observers think that’s not enough of a come-on and expect ACOs that have heretofore avoided downside risk to balk at this effort to make them accept it. CMS is “pulling the rug out from ACOs by redoing the program in a short timeframe with untested and troubling policies,” says Clif Gaus, president of the National Association of ACOS (NAACOS). He predicts an “exodus” from the program.

“I do believe there’ll be an impact, but there would have been anyway,” says John Wagner, associate director of the health care performance improvement practice of the Berkeley Research Group in Emeryville, Ca. “CMS forecasts that [under this rule], 109 ACOs will leave the program over 10 years. But the program currently requires leaving the upside-only model after six years.” Given the number of upside-only ACOs still in the program, he says, “over the next year or two, you were going to lose a number that exceeds that anyway.”

“From the perspective of the program,” losing risk-averse entrants could be “a good thing,” says David B. Muhlenstein, chief research officer at Leavitt Partners LLC in Washington, D.C. “The analogy I use is forest management – what is good for the forest may not be good for any one tree.”

Theresa Hush, CEO and co-founder of Roji Health Intelligence in Chicago, warns providers that the rule is further proof that CMS’ push toward value-based care is unstoppable.

“If providers want to direct their future rather than just be a participant in managed care, they really ought to think twice about moving forward,” says Hush. “They don’t have much time. No matter how they choose to participate, there won’t be any alternative to saving money.” (*See more analysis of this rule at the Part B News blog at <https://pbn.decisionhealth.com/Blogs/default.aspx>.*)— Roy Edroso ([redroso@decisionhealth.com](mailto:redroso@decisionhealth.com))

### Resources:

- ▶ “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success”: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-17101.pdf>

(continued on p. 6)

## Benchmark of the week

### Double-check critical care services reported with modifier 25

Practices that bill for critical care services (**99291-99292**) should make sure everyone understands the coding rules for these high-value codes, as well as the use of modifier **25** (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) with critical care services. The combination of critical care and modifier 25 is on auditor radar and could trigger denials.

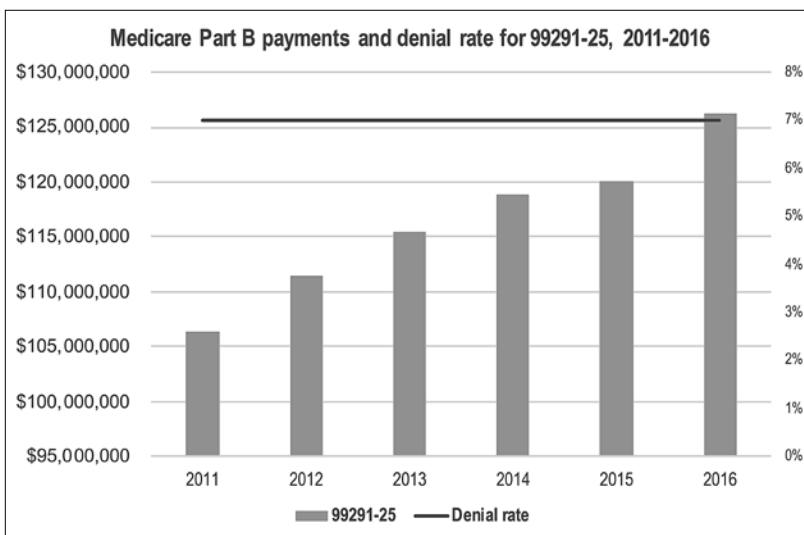
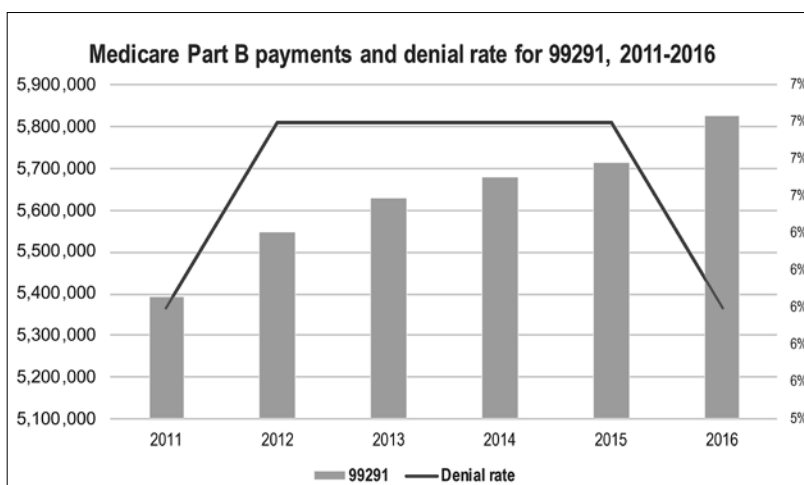
eGlobalTech, the division of Palmetto GBA that performs comparative billing reports (CBR), recently reviewed critical care services. In its rationale for the review, it cited findings in the latest comprehensive error rate testing (CERT) report. According to the supplemental data report for 2017, critical care was high on three top 20 lists for improper payments.

However, the CBR went beyond the CERT report's findings and looked at the use of modifier 25 with critical care services. You may report a critical care service on the same day as another E/M service, with the exception of emergency department visits (**99281-99285**). Modifier 25 should be appended to the primary critical care code (99291) when the service meets the requirements for modifier 25.

The following charts compare revenue and denial rates for 99291 and 99291-25 for the years 2011 through 2016. Note that revenue rates have steadily increased, but denial rates have shown little or no fluctuation. — *Julia Kyles, CPC* ([jkyles@decisionhealth.com](mailto:jkyles@decisionhealth.com))

#### Resources:

- ▶ CBR201804, critical care services, webinar handout: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf)
- ▶ CERT 2017 Medicare fee-for-service supplemental improper payment data: [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf)



Source: Part B News analysis of Medicare claims data



(continued from p. 4)

- ▶ “Pathways To Success: A New Start For Medicare’s Accountable Care Organizations,” Seem Verma, Health Affairs, Aug. 9: [www.healthaffairs.org/doi/10.1377/hblog20180809.12285/full](http://www.healthaffairs.org/doi/10.1377/hblog20180809.12285/full)
- ▶ “Medicare Program Shared Savings Accountable Care Organizations Have Shown Potential For Reducing Spending And Improving Quality,” OIG, August 2017: <https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf>
- ▶ “Medicare Accountable Care Organization Results For 2016: Seeing Improvement, Transformation Takes Time,” Health Affairs, Nov. 21, 2017: [www.healthaffairs.org/doi/10.1377/hblog20171120.211043/full](http://www.healthaffairs.org/doi/10.1377/hblog20171120.211043/full)

## Physician payments

(continued from p. 1)

Donelson in Fort Lauderdale, Fla. Only legislative activity could revise the “originating site” requirements baked into telehealth services that have long befuddled health care providers (*PBN* 4/30/18).

Among the creative solutions are two proposed codes that would allow providers to wield a smartphone to conduct a brief patient encounter and get paid for doing so. The first service, represented by the following placeholder HCPCS code, is essentially a quick chat or video call with a patient:

- **GVCII** (Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).

The service, which would pay about \$15, is intended to capture instances when a provider can “assess whether the patient’s condition necessitates an office visit,” CMS states in the proposed rule. For instance, a patient may call with complaints of a sore throat, and a provider can ascertain the patient’s condition and provide a course of care. “Essentially, this is a triage service,” Goldman says.

But watch the fine print: You can’t report the code if you’ve seen the patient within the past week or if the patient comes in for a face-to-face visit within the next 24 hours. Also, the code calls for at least five to 10 minutes of time spent with the patient, which could be prohibitive given the low monetary value of the code. “People are going to be disappointed when they realize what

the payment will be,” says Betsy Nicoletti, president of Medical Practice Consulting in Northampton, Mass.

Providers also may run into problems of medical necessity for the code, Goldman warns. That’s because CMS expects that the service “would be initiated by the patient” but that “like any other physicians’ service, [it] would need to be medically reasonable and necessary in order to be paid by Medicare.”

What would make an appropriate virtual check-in remains something of an open question. “How do you police medical necessity?” Goldman asks.

In the proposal, CMS does not place any frequency limitations on the code. The agency also proposes to open the door to alternative uses of the service, specifically stating that it “could be used as part of a treatment regimen for opioid use disorders and other substance use disorders since there are several components of Medication Assisted Therapy (MAT) that could be done virtually.”

## A picture is worth 1,000 words, maybe \$13

With the proposal of a code that allows providers to assess images or videos, you’ll find another way to get paid by tapping into your tech. Known as a “store and forward” evaluation, the new service contains the same calendar caveats as the virtual check-in code, meaning you’ll have to be careful about a related E/M visit. Here’s the full description of the placeholder HCPCS code:

- **GRAS1** (Remote evaluation of recorded video and/or images submitted by the patient [e.g., store and forward], including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment).

“I think store and forward is a major step forward,” says Krista Drobac, executive director of the Alliance for Connected Care in Washington, D.C. The code, which is slated to pay about \$13, could have a wide range of applications for primary care physicians and specialty doctors, such as dermatologists. Things like “wounds, rashes, bites, swelling or edema” all would be likely conditions to monitor virtually, Nicoletti says.

However, given that the rule bundles the store-and-forward service into an E/M visit that occurs within the past week, providers would miss taking advantage of important follow-up care, Drobac says. For instance, a dermatologist who treats a patient’s rash during an office visit may want

to view the condition after three days. Under the current proposal, using store and forward during that timeframe would be bundled into the E/M encounter.

## Find peer-to-peer payments

In addition to the patient-to-provider services that you may find unlocked in 2019, CMS is proposing to pay for a series of six “interprofessional internet consultation” codes that would reimburse a treating or consulting physician when collaborating on a patient’s treatment plan. The agency said in the proposed rule that it would unbundle four current codes — **99446-99449** — that pay a consulting physician for providing a report to the treating physician.

Also, CMS announced it would pay for two new interprofessional consult codes in 2019 represented in the rule by two placeholder codes — **994X0** (Interprofessional telephone/Internet/electronic health record referral service[s] provided by a treating/requesting physician or qualified health care professional, 30 minutes) and **994X6** (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time).

“Proposing payment for these interprofessional consultations performed via communications technology such as telephone or Internet is consistent with our ongoing efforts to recognize and reflect medical practice trends in primary care and patient-centered care management,” CMS states.

Take note of a big red flag when considering these services, warns Nicoletti. CMS proposed that providers will need to gain patient consent and note it in the medical record. “How are you going to get verbal consent from the patient?” she wonders. It could be problematic for providers who are seeking consultative advice on the fly and, additionally, patients would be subject to a copay when the interprofessional services are used.

CMS is seeking comment on whether gaining consent is practical. Also, be on the lookout for updates to available service settings for the interprofessional codes. A code-valuation addendum to the proposed rule shows that the services are payable only in the hospital, but Nicoletti says a CMS spokesperson told her that the codes will be paid at the same value in the non-facility setting. — *Richard Scott* ([rscott@decisionhealth.com](mailto:rscott@decisionhealth.com))

## Patient encounters

*(continued from p. 1)*

and large practices. They found that “practices with 100+ physicians and 50–99 physicians had, respectively, annual spending per high-need beneficiary that was \$1,870 (12.5%) and \$1,824 higher than practices with 1–2 physicians, and readmission rates 1.64 and 1.71 [times] higher.”

The authors acknowledge that their findings “are not consistent with the widely held belief that larger organizations provide better care,” given that large practices are “likely to have more financial resources and potential economies of scale than smaller practices and independent practices.” They suggest that perhaps “smaller independent practices may support close relationships of mutual knowledge and trust among physicians, staff and patients that may be associated with better outcomes.”

## Obstacles for larger providers

The fast growth of the current consolidation-crazy era may have something to do with the results, says Pamela Ballou-Nelson, RN, CMPE, MA, MSPH, principal consultant with the Medical Group Management Association (MGMA) in Englewood, Colo. (*PNB 3/24/17*). “A lot of practices became large due to M&A [mergers and acquisition],” she says, “so, to give them the benefit of the doubt, maybe they haven’t quite figured out how to integrate and aggregate all the pieces yet to acquire efficiencies.”

But some of it is part and parcel of being a large practice, says Ballou-Nelson. “It’s all about relationships,” she says. “And it’s harder to establish those in a large organization with all its layers and often bureaucracies to sort through.”

“The bigger the group, the more complicated everything becomes, from scheduling an appointment to introducing new treatments,” says Paula Muto, M.D., founder and CEO of UBERDOC, a “patient-to-specialist” direct access web app company in Andover, Mass. “Bigger groups have multiple providers and follow workflows that accommodate scale.”

## Consolidate smarter

Bigger doesn’t have to mean worse, though. Louis Levitt, M.D., vice president of the Centers for Advanced Orthopedics in Bethesda, Md., a group with 157 providers in 60 locations, believes his group’s experience “contradicts the premise that consolidation costs more and may

not provide better clinical outcomes” — mainly because its “decentralized” approach lets “divisional managers responsible for the day-to-day operations of the local centers” set their own course, says Levitt, with management mainly doing housekeeping such as insurance, legal and clearinghouse work.

Those efficiencies save money on overhead and allow the Centers to make investments that reduce the cost of care, says Levitt. “We’re moving out of the hospitals, which directly affects the cost of care,” says Levitt. “In the last two years, we’ve moved 30% of our joint-replacement procedures to outpatient surgery.” Levitt estimates this cuts the cost of joint-replacement surgery by 50%.

You can also get big-practice efficiencies with small-practice advantages by enlisting in a model that lets you stay independent, such as a clinically integrated network (CIN) or an independent physician network (IPN), says Ballou-Nelson. While retaining control of your future, you can enter group purchasing deals and “go to the payers with a collective value-based plan to improve outcomes and decrease costs over time,” she says.

## 5 ways to encourage transformation

- **Shop for an innovative pilot program.** CMS’ Center for Medicare & Medicaid Innovation (CMMI) programs can help tone up your patient care. Ballou-Nelson mentions as an example Transforming Clinical Practice Initiative (TCPI), a CMMI program “designed to help clinicians achieve large-scale health transformation. The initiative is designed to support more than 140,000 clinician practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies.”

- **Teach patients to take care of themselves.** “You’ll never bring costs down if the patient is not coached in self-management,” says Ballou-Nelson. Medicare pays for diabetes self-management training (DSMT) and medical nutrition therapy (MNT) under some circumstances (*PBN 5/11/15*). And teaching patients to better express their needs to providers should improve the clinical experience (*PBN 8/9/18*).

- **Go for patient relationship management (PRM).** Heidi Jannenga, PT, president and co-founder of WebPT, a physical therapy coding software company in Phoenix, recommends PRM products that maintain contact with patients as the practice grows. At their most basic level, they “allow providers to set up automated communications

like appointment reminders, treatment follow-up emails, birthday wishes or general tips for maintaining health and strength,” says Jannenga. But they can also work like the advanced customer relationship management (CRM) tools used by other kinds of businesses to help practices “monitor the quality of the experience they are delivering by collecting customer loyalty data, extracting and analyzing data to drive business decisions and shape care delivery models.”

- **Refer to patient advocates.** Private patient advocates, as opposed to ones employed by payers or hospitals, are usually self-pay services, says Teri Dreher, CEO of NShore Patient Advocates in Chicago, though some long-term care insurance plans cover them. But they can fill a lot of care gaps for busy providers, from patient education to community outreach.

For example, says Dreher, NShore recently helped a primary care patient with multiple needs — “50 years old with cerebral palsy, brittle diabetes and lived alone, with only volunteers from her church to help her.” Dreher’s patient advocates spent hours on complex care management, Medicaid planning and getting the patient into a quality supportive living community. You can find an advocate in your area via organizations such as Alliance of Professional Health Advocates (APHA).

- **Disrupt. Go for “transformative” change in your practice.** “It’s not ‘practice improvement’ — taking what you already have and improving it,” says Ballou-Nelson. “Transformation is looking at where we need to be and at what we have to change to make it happen.”

This could mean plugging in virtual visits, telehealth, home visits and other non-traditional models — or just responding to immediate circumstances. For example, while working with the Colorado Children’s Access Program, Ballou-Nelson found doctors who were doing well-baby visits and giving mothers the Edinburgh maternal depression scale — and discovering a number of moms with serious depression. “We’re so conditioned to think we have to do things a certain way: Hell or high-water, this is the well-baby visit,” says Ballou-Nelson. “But if the problem at hand is the mother, that’s what you should take care of.” — Roy Edroso ([redroso@decisionhealth.com](mailto:redroso@decisionhealth.com))

### Resource:

- “Medical Group Characteristics and the Cost and Quality of Care for Medicare Beneficiaries,” Health Services Research, July 5: [www.ncbi.nlm.nih.gov/pubmed/29978481](http://www.ncbi.nlm.nih.gov/pubmed/29978481)



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