



How Will Podiatry Deal with Value-Based Care?

Clinical integration may well be the best preparation for the upcoming changes.

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The greatest challenge facing United States healthcare today is how to deliver greater value to the consumer. Value defines the relationship between cost and quality. Measures of quality include such factors as: patient outcomes,

experience, and satisfaction. According to the Commonwealth Fund 2014, the U.S. finishes last when comparing healthcare outcomes and cost among developed countries.¹ The United States spends a much higher percentage (20%) of its gross

innovative approaches to care, it has accelerated efforts to deliver greater quality care per dollar spent. Broadly, this transformation describes a change from a system of care that pays providers based on the quantity of care—fee-for-service (FFS)—to one

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domestic product (GDP), the value of all goods and services produced, than does any other developed nation (Germany 11%, Japan 10%, Canada 11%).²

The aging of our population, the prevalence of obesity, and the preponderance of such chronic conditions as diabetes, arthritis, and hypertension make the cost for providing care, based on our fee-for-service model, not financially sustainable. While the full effects of passage of the 2010 Patient Protection and Affordable Care Act (ACA) have yet to be felt, by the creation of several

based on the quality of outcomes—fee-for-value (FFV) or value-based care (VBC).

With disruption of our current care model comes an opportunity for providers to look strategically to develop compensation models which foster current income, wealth creation, and capital to grow. The emergence of large provider groups is built off the idea of clinical coordination, leverage of ancillary services, and participation in value-added insurance arrangements.

How Value-Based Care Is Affecting Podiatry

In many ways, podiatry is well positioned to benefit from initiatives that incentivize a preventative approach to care. The New York State Podiatric Medical Association recently released a report summarizing changes in the healthcare landscape and it included proposals about how podiatrists can best play a role. An example is the state's Delivery System Reform

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Incentive Payment (DSRIP) program. It aims to reduce avoidable hospital use by 25% over five years by shifting at least 80% of Medicaid payments from fee-for-service to a number of value-based arrangements.

Examples of NY Value-Based Payment initiatives include: Total Care for the General Population (TCGP):

- Providers are responsible for the total care of its attributed population

Integrated Primary Care (IPC)—Patient Centered Medical Home includes:

- Care management with practice transformation to coordinate with behavioral health initiatives

Chronic Care Bundles: all costs related to the episode across the care continuum are measured

- Includes 14 chronic condition including: diabetes, substance abuse disorder, lower back pain and osteoarthritis

Total Care for Special Subpopulations

- Managed long-term care³

The New York State Podiatric Medical Association (NYSPPMA) is advocating that as podiatrists address conditions including diabetes, obesity, and back pain/substance abuse that affect benchmarks set by the state commission, they can play a valuable role in the integrated care model. “While current Medicaid coverage for podiatric services in NY is limited, expanded coverage of podiatric services in inclusion of podiatric services in value-based payment arrangements may result in reduced inpatient admissions and decreased healthcare cost.”⁴

What Is Clinical Integration and What Benefits Does It Offer Podiatrists?

The greatest challenge facing the healthcare industry is improving the value proposition to the consumer. A solution to this challenge is tighter clinical integration between providers. Clinical integration (CI) is a collaborative and coordinated focus on reliably producing high-quality clinical outcomes in the most cost-efficient manner possible, holding accountable those responsible for healthcare delivery. Creating successful clinical integration (CI) entails economic, legal, and cultural integration and can work in a FFS, FFV, or any combination of the two environments.

While innumerable value-based care models have been developed, most share the following important characteristics:

- Alignment of physicians and care teams with patient needs, better outcomes, and lower costs.
- Team-based care that engages patients as consumers in convenient settings with comprehensive services.
- Supportive infrastructure that reduces administrative burdens and costs while enabling engagement, experience and service.
- Coordinated care services that promote early diagnosis, prevention, and appropriate care interventions.
- Robust data sourcing, analytics, and technology to

identify risk, improve performance, and enhance growth.⁵

Clinical integration benefits under a fee for service (FFS) model:

1) Improved quality and patient safety which will attract larger numbers of patients and providers who can deliver promised outcomes.

2) Lower costs that will preserve margins as FFS payments flatten or decline.

3) Access to healthcare systems interested in partnering with and rewarding physician groups focused on

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quality improvement and cost reduction.

Advantage of Clinical Integration in a value-based reimbursement (VBR) setting:

1) The ability to receive bundled payments, shared savings, and capitation.

2) The ability to capture and control market share through the provision of population health management services to payers and large self-insured populations.

3) The establishment of a work environment where efforts other than productivity are valued and rewarded.

4) The formation of a sustainable care delivery model that incorporates physician buy-in and value-centric practices that keep the cost structure down.

Early attempts at clinical integration invested heavily in information technology (IT) systems that allow real-time sharing of data but lacked widespread input from front-line physicians. This created a missed opportunity to control costs without sacrificing quality and patient safety. With the continuation of such value-based reimbursement models as the Medicare Value-Based Reimbursement Program, the CMS Bundled Payment Pilot Program, and the Medicare Shared Savings Program (MSSP), there are strong financial incentives to increase clinical integration to achieve high quality clinical outcomes while reducing waste and inefficiency. Clinical integration and accountable care offer the promise of greater value to patients, providers, and physicians and is not dependent on the payment mechanism.

Podiatric Practice Possibilities

While in the past, physicians had the privilege of practicing independently, healthcare today is much more a team sport. A collaborative approach does not come easily to many older physicians who have prospered in a “winner take all” environment. Likewise, hospital administrators have often viewed physicians as a group to be tolerated at a safe distance, and not to be permitted too much influence over the financial, legal,

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or business management aspects of the organization.

Podiatrists, like all U.S. physicians, are increasingly facing pressure to adjust the way we practice, whether it is to take on associates or partners, merge with another practice, or join a hospital-based system. The demand for delivering greater value that is imposed on hospitals, healthcare administrators, and physicians can make it feel that staying the same is just not an option. We need to consider with whom to align to best attain a position that offers the best way to practice medicine. What's increasingly unavoidable is that physicians and hospitals, despite a history that frequently includes mistrust and lack of appreciation, need each other to address the demands of healthcare delivery.

Gone are the days when private practices could reliably count on expenses less than 50% of revenue. As the cost of overhead has increased and reimbursement has diminished, the percentage of collections that can be retained has steadily shrunk. Practices have had to consistently manage their expenses, look for ways to grow revenue, and plan for ongoing changes in reimbursement models. Looking ahead, practices can expect reimbursement to place greater emphasis on cost-effective delivery of high quality, repeatable outcomes.

The financial and operational challenges associated with being in private practice have led more than half of all physicians to be employed by hospitals or other healthcare delivery systems. This is unfortunately often not working out as wished for by either party. Many physicians find the bureaucratic requirements of working in a large organization unbearable and many hospitals are finding that physician employment contracts are financially not sustainable.

Increasingly, practitioners in solo and small practices are finding the responsibilities just too difficult to sustain and financially are not viable. More and more practitioners are looking to grow by combining with other groups in order to gain advantages whereby they can:

- Capture and control market share through the provision of population health management services to payers and large, self-insured employers;
- Create a work environment where efforts other than productivity are valued and rewarded;
- Form a sustainable care delivery model that incorporates value-centric practices that aim to keep the cost structure down.

Variables to Consider When Contemplating Joining a Hospital System vs. Joining Another Practice

When weighing the advantages of becoming employed by a hospital system or considering joining a larger, already established group, practitioners are advised to first assess the current state of their practice and make realistic expectations of where it expects to be. Elements to examine include:

- Financial sustainability (revenue, profits)
- Practice culture
- Management structure and staffing

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- Coding and compliance
- Operations
- Quality

Prior to any combination, physicians should have frank discussions among themselves about what's most important to each, what they hope to achieve, and understand what they like in the present set-up and how such factors can be preserved in the combined entity. Before combining practices, podiatrists are advised to explore various options in order to gain a more realistic perspective of the benefits and sacrifices that alignment requires.

When a practice contemplates joining another, there are numerous logistical as well as cultural factors to consider in order to achieve the sense of control that drives most podiatrists to effect such a major change. Often the choice comes down to comparing becoming part of a hospital system versus aligning with a competitor. Working with a former competitor should not be seen from a win-lose perspective but rather a way to reinforce strengths and augment weaknesses with the ultimate benefit of improving the quality of patient care. It's important, regardless of which path is chosen, to consider how practice styles, culture, and perspective of quality match up.

When considering partnering with a hospital in an employment model, some implications may include:

- Physician Benefits
 - Better and more stable compensation
 - Improved benefits (retirement plan, medical, etc.)
 - Improved access to capital
 - Reduced headaches associated with practice running
- Physician Challenges
 - Having to work within a larger bureaucracy
- Loss of individuality
- Loss of income associated with ancillary services
- Loss of authority over staff
- Often increases in salary and benefits for staff

When considering partnering with another group, some implications may include:

Financial Sustainability: While practices that have focused on improving efficiencies and reducing costs are better positioned to work with changing payment models, it should not be assumed that such a strategic approach will remain viable. Revenue streams to the practice are bound to change as reimbursement models increasingly reward better management of disease states, which focus on cost-effective delivery of high-quality,

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repeatable outcomes. Practices will need to learn activity-based accounting and leverage the data created by their EHR to better manage and measure the cost aspect of care delivery while still producing the desired quality outcomes.

Culture: There's an expression that "culture trumps strategy." As important to the implementation of effective treatment protocols when practices combine is the significance of the "cultural integration" required for putting former competitors on the same team. Every practice has its own "vibe", its way of doing things. It drives how patients are treated, how the staff functions, and how physicians perform. Some factors that can offer insight into how well-matched practices are include:

- Do physicians socialize outside of work?
- Are offices clean and organized?

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- Is equipment clean and well maintained?
- How are employed physicians versus partners treated?
- What are the average ages of the group?
- Are the older physicians on a retirement track?
 - Is there a defined path for slowing down?
 - Does the process entail pay reduction?
 - Are these items addressed in partner, employment, operating agreements?
- What are the work habits of the group?
- How alike are the organizational structures of the combining groups?

Management and Staff: Combining practices brings the promise of increased efficiencies and streamlining of processes. Invariably, there is also a need to eliminate redundancies of roles. When planning the practice consolidation, it's always best to consider the organizational structure that would work best for the combined entity and to define the most important responsibilities for each of the defined roles. When deciding on the people who are best for every position, confirm that each embodies the qualities determined to be defining of the practice culture. Consideration should be given to ensure that in every role, the assigned person satisfies "G, W, C"; G means that they "get" what the role requires and understand how to do the job, "W" means that they "want" the

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position and have the desire to do it, and “C” refers to “capacity”, that they have the time and the innate ability to do what’s required to do the job well.

Coding and Compliance: Coding with appropriate supporting documentation is the driver of practice revenue. Practices should have protocols in place to ensure that providers are billing correctly. This should be supported by education and retrospective random chart reviews to ensure that documentation and coding match what was billed. A practice compliance plan should offer staff anonymity for reporting perceived coding and billing issues and should offer a remediation pathway to ensure that flagged issues are promptly addressed.

Operations: An operational review should start with the lifecycle of a practice visit. The review should begin with patient check-in and registration. It should then move to the clinical area to review patient treatment, how the EHR integrates, use of physician extenders, employment of ancillary services, patient check-out, and scheduling. All these steps should be considered from the perspective of looking for efficiencies and optimizing the “cost of doing business”. Another review entails the flow of revenue, from patient prior authorization to collection of co-payments and deductibles, to determination of charges, to billing and appeals.

An operational review should include patient access, provider schedules, visit timeslots, and office hours. Included in the operational review should be assessment of HIPAA (Health Insurance Portability and Accountability Act). A practice that runs with an operating expense ratio that far exceeds 50% of revenue may be understood to be most motivated to offset overhead compared to other benefits of integration. Such an understanding helps to define leverage when conducting negotiation. A more in-depth review of a practice’s operation might entail some of the following:

- What are the fixed costs?
- What are variable costs (costs that vary based on use)?
- How is physician productivity measured (RVUs, wRVUs, collections, billing)?
- Does the group know what they earn for every procedure from every payer?
- Does the practice have a plan for verifying that reimbursements are accurate as per agreed-upon fee schedule, and appealing if not?

Quality: We are entering a new era where practitioners will be increasingly measured and compensated based on some measure of the quality of their care delivered. This may be defined as fewer re-admissions, more management of patients in outpatient settings, and increased reliance on ambulatory care, including telemedicine. Our present healthcare system abounds with duplicate and often inconclusive tests, waste, and inefficiency. An overriding objective is to better manage patient care

at lower cost, and reduction of inappropriate testing is a key driver of this. Physicians looking to join a larger enterprise would be wise to ask questions regarding quality such as:

- Does a quality committee exist?
- Is provider compensation in some part predicated on measured and monitored quality outcomes?
- Do the practices view quality by the same parameters?
- What accountability exists to hold physicians to a standard of care?

Integrating 1,2,3

Once a practice joins another, it’s generally a several year-long process to integrate protocols, achieve the benefits that drove the merger, and ultimately improve patient care. A gap analysis entails comparing how the practice is functioning in the current state to its desired goal. Objective assessment with prioritization of items needing addressing should be the regular focus on an on-going basis. Challenges that can be anticipated fall into several areas:

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1) Strategic planning: there should be ongoing assessment of how the original vision for the combined entity compares with present-day desires and realistic expectations.

2) Operational: implementation of “best practices” requires ongoing review of needs, training, supervision, and reporting. Metrics should be reviewed on a regular basis to ensure they can be accurately and efficiently reported and that they are chosen selectively to give a realistic pulse of the organization.

3) Governance: Physician leaders are required to ensure effective oversight and decision-making. Compensation issues require both administrative and clinical perspectives.

4) Financial: There needs to be on-going monitoring of how transformation from fee-for-service is affecting practice revenue and how to maximize compensation given new value-based payment models.

5) Legal and contractual: Many different service arrangements between hospitals and physician groups exist. Consideration must be exercised that among other things, Stark/Anti-Kickback and patient privacy requirements are adhered to.

Recommendations for Successful Reform Implementation

Take a Long-term Approach: It’s fundamentally essential that all parties share a common long-term vision

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that is committed to achieving the triple aim of healthcare reform:

- Excellent patient centered care for each individual patient
- Overall improvements in population health
- Cost reduction throughout the healthcare system

Allow the Process to Drive the Culture: nothing breeds success like success. While differences in organizational cultures are challenges to effective integration, working the process to implement operational processes will often help to move the cultural integration along.

Come Together with a Common Purpose: Make it clear to all physicians and other providers that they are working to deliver high quality patient care. As long as physicians understand that changes are relevant to improving patient care, engagement and alignment will most easily follow.

Don't Rush the Transaction: Long standing cultural norms do not evaporate overnight. Everyone involved in the process must be committed to the process and understand that improvements will take time to occur. Keeping the long-term vision clear will help

the practice get through the inevitable rough patches of the transformation.

The Future of Podiatry in a Value-Based World

The transformation of healthcare is fundamentally happening at the level of practices merging, and this requires integration on many levels. We have a delivery system that developed based on very different needs from what our society faces today. Alignment and inte-

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gration are happening all around and are creating meaningful change and true healthcare reform on a steady basis. Physicians in private practice are wise to understand the macro forces in play and how their professional situation can be best positioned to work in a more collaborative, value-based, patient-centered approach to care.

Podiatrists, as cost-effective providers of common chronic conditions, are well positioned to play a valuable role in value-based care delivery models. By forming large, professionally-managed groups, there is the opportunity to participate in new compensation models that can create wealth for practitioners while delivering more cost-effective care to patients. There are many challenges but by acquiring an understanding of clinical coordination and value-added insurance arrangements, podiatrists can thrive. **PM**

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