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New Ways for Patients to Rate Physicians

"Consumers are doing more shopping, and we're seeing a greater demand for information," La Penna said.

The new insurance exchanges are supposed to be the next step in healthcare consumerism. Enrollees can compare insurance plans side by side, based on cost and other features, which can't be easily done in the current insurance market.

Healthcare consumers can also pick a physician by going to the Physician Compare Website, which CMS rolled out in December 2010 and significantly upgraded this past June. Consumers can now search for physicians by name, medical group, hospital affiliation, address, ZIP code, and proximity to a shopping center or other landmark. They can also look for physicians who are board-certified or participate in the meaningful use program.

In 2013, Physician Compare was supposed to add quality data gathered by PQRS, but that has been postponed until next year, according to an email from a CMS spokesperson. In early 2014, he said, the site will include 2012 PQRS data from group practices and ACOs. CMS has agreed to a 30-day preview period for physicians to view their information before it is posted.

In a recent letter to CMS, the American Medical Association (AMA) criticized the updated Website.[11] The AMA's concerns about Physician Compare included "inappropriate results when searching in a specific medical practice" and use of CMS specialty categories rather than physicians' own categories.

Keegan says that physicians are right to be nervous about what will be posted on Physician Compare, because it will become a very useful consumer tool. "You would want to make sure that your performance on the site is competitive," she said.

La Penna said that when Physician Compare begins including quality information next year, it will be a significant improvement over physician-ratings Websites like Yelp, HealthGrades, and Angie's List, which are very subjective. "Angry people go to these sites and make a comment," he said.

Accepting the Future of the ACA

Until last year, many physicians expected that the ACA could easily be repealed and they might never have to deal with it.

Then came the Supreme Court decision upholding most of the law, followed by President Obama's reelection, and the outlook changed. A 2013 survey by Deloitte[12] found that 8 in 10 physicians thought the law would continue as planned.

Even Dr. Gottlieb, who does not like the new law, thinks it is here to stay. "I don't think the ACA will get repealed," he said. "Once all those subsidies are in place, they are going to stay."

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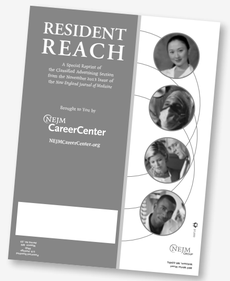

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INSIDE THIS ISSUE

8 Ways That the ACA Is Affecting Doctors' Incomes

By Leigh Page

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The ACA and Physician Reimbursement

As the Affordable Care Act (ACA) moves toward its key implementation phase next year, this massive law is starting to affect physicians' incomes in a variety of ways.

In January 2014, the ACA will carry out the largest insurance coverage expansion since 1965 and make historic changes in the way that insurers operate. Other changes that affect physicians have already been initiated, and more will follow.

Here are 8 ways that the ACA is likely to affect your income. Is your practice ready?

More Covered Services

The new law removes some major impediments in insurance coverage for your patients and mandates some extra services that your payers may not have covered previously.[1]

"There are strong feelings for and against the ACA, but this group of provisions has broad support," said Jeffrey Cain, MD, President of the American Academy of Family Physicians (AAFP). He added that these reforms would help physicians because "patients who have insurance and access to primary care have better health outcomes."

In 2011 and 2012, the ACA required insurers to cover 63 different preventive services without requiring an out-of-pocket payment from patients.[2] The services include blood pressure and mammography screenings, a variety of immunizations, childhood behavioral and autism screenings, and — controversially — access to contraception. Practices can expect reimbursement for these services without needing to collect any money from patients.

Then, on January 1, 2014, individual and small group plans will have to cover specific services, called "essential health benefits," including maternity care, mental health services, medications, rehabilitation services, and chronic disease management. Again, insurers will have to pay physicians and other providers for these services.

Also, plans will be barred from discriminating against people for pre-existing conditions, and they cannot set annual or lifetime limits on coverage. These provisions will be important to your patients with chronic conditions who currently can lose coverage when they switch jobs and may have bills that exceed their insurance limits.

More Patients With Coverage

Also next year, millions of newly insured Americans will be looking for a primary care physician and eventually specialists as well. Enrollees in the new health insurance exchanges will be mostly low-income people who will get subsidies to buy coverage and pay out-of-pocket charges.[3]

The other sector of newly covered Americans will be part of the ACA's expansion of Medicaid coverage to those living at 138% of the federal poverty level. This will be crucial for low-income childless adults, who currently have little or no coverage. However, the Supreme Court last year allowed states to reject the Medicaid expansion. Even though they would not have to pay anything for the first 3 years of the expansion, approximately half of the states are refusing to participate.

Dr. Cain said that coverage through the exchanges and the Medicaid expansion will

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be a boon for family physicians, who see an average of 8 patients a week on a discounted or free basis. "This new coverage will mean that family physicians can have a financially viable practice," he said.

Exchange plans have not yet announced reimbursement rates for physicians, and it's not clear yet whether rates would be lower than those of other commercial plans. Because exchange plans serve a low-income population, they are under a great deal of pressure to keep premiums affordable. To keep costs down, many exchange plans have won discounts from hospitals by excluding high-priced hospitals from their exchange networks and rewarding in-network hospitals with higher volume.

The Game May Play Out Differently

Exchange plans' discounts-for-volume tactic may not work on physicians. Many practices already have full appointment books and are not interested in getting more patients. In fact, there are signs that a large proportion of physicians will refuse to join exchange plans, which would mean that exchange plans would have to offer reasonable rates just to have enough physicians in their networks.

Some exchange plans, concerned that their networks do not have enough physicians for the new enrollees, are reportedly pressuring more physicians to sign up. Physicians who already have contracts with an insurer in the exchange may have an "all-products" clause requiring them to take the exchange product, too.

Louis J. Goodman, PhD, President of the Physicians Foundation, which has been polling physician attitudes, said that many physicians think the exchanges won't open on time or will be very disorganized. "A lot of practices are thinking twice about joining exchange plans," he said. "They are going to wait and see." He said that uninsured patients who enroll in the exchanges will not be familiar with insurance ID cards, paying deductibles, and coverage limits, and may need some education.

However, even in full practices, physicians who have a lot of elderly Medicare patients may want to change their payer mix. Accepting exchange patients is a way to get younger patients, according to Jim Walton, DO, CEO of Genesis Physicians Group, an independent practice association in Dallas. He said that lots of younger patients, who need fewer health-care services than older patients, are expected to go on the exchanges.

Also, physicians signing on to an exchange plan will have no idea how many patients they will get from the plan until after enrollment starts on October 1, 2013. Will they have enough time to expand their operations to meet the extra demand by January 1, 2014?

Judith Aburmishan, a partner in charge of healthcare consulting services at FGMK LLC in Bannockburn, Illinois, advises physicians to proceed in steps. "When your volume grows, the first step is to add on hours," she said. "Later you might hire a new doctor or a nurse, or you might weed out the poor payers and drop your worst-paying insurance plan."

Physicians Have to Deal with Higher Out-of-Pocket Payments

The ACA and the exchanges follow a rising trend toward higher out-of-pocket charges, which is forcing practices to rethink payment policies for patients.

According to surveys by the Kaiser Family Foundation,[4] the percentage of covered employees having a deductible for single coverage rose from 52% in 2006 to 72% in 2012. In 2012 the average general annual deductible for this population was $1097, an 88% increase since 2006, the Foundation reported.

Health insurance exchange plans will have relatively high out-of-pocket payments. In the benchmark "silver" plan on the California exchange, for example, an enrollee with a $45,000 annual income would have a $2500 deductible and copays of $45 to $65 for an office visit.[5]

Deborah Walker Keegan, PhD, President of Medical Practice Dimensions, a consultancy in Asheville, North Carolina, said that high out-of-pocket payments have the biggest impact on specialists with expensive services, such as orthopedic surgeons, but they can also be a problem for primary care practices because they can add up quickly.

Keegan added that it's difficult for a practice to calculate how much the patient owes at any given time, because the deductible changes each time the patient pays for care, although some payers provide real-time information on members' out-of-pocket levels.

To make sure that the out-of-pocket charge is collected, Keegan said that a practice has to collect these charges up front, prior to providing care. "If patients don't have the payment at the time of service, then you might ask them to agree to a budget plan and set up credit card payments," she said.

Aburmishan, the Illinois consultant, says that some practices are asking patients to provide their credit card number and give permission to draw payments from it. If the practice's first attempt to file a claim is denied, it would charge the card for smaller bills; for larger bills, it would take $500 off the credit card each month, she said.

Primary Care Gets a Boost

"The ACA is increasing the prestige of primary care, "said AAFP's Cain. He noted that many key aspects of the law favor primary care, such as enhanced reimbursements under Medicare and Medicaid, new models of care like the patient-centered medical home, and preventive and wellness services covered under the "essential health benefits."

Specifically, Medicare is paying primary care physicians a 10% bonus for primary care services from 2011 through 2015, and primary care physicians' Medicaid reimbursements for evaluation and management services and vaccinations are being raised to Medicare rates in 2013 and 2014. Due to start-up problems, the Medicaid payments are just beginning to come through.

Dr. Cain also pointed to new programs by commercial insurers oriented to primary care. WellPoint, for example, has increased reimbursement to primary care physicians for services such as "nonvisits" over the phone and will award them up to 50% more than they had been earning for reducing medical costs while maintaining quality.[6]

Dr. Cain said that a key outcome of the ACA's emphasis on primary care is that it "puts more emphasis on the need for these kinds of doctors."

New doctors have been heeding the call, partly due to new subsidies for primary care training. The number of medical students committing to primary care programs in the Match has increased every year since the ACA was passed in March 2010.[7]

Physicians Head for Larger Entities

Even before the ACA, hospitals were beginning to buy up physicians' practices. Michael La Penna, a healthcare consultant based in Grand Rapids, Michigan, said that the trend has stayed strong, partly due to the law's strong endorsement of Accountable Care Organizations (ACOs), which bring together the whole spectrum of providers.

"Solo practices need to align with someone bigger," he said, citing falling reimbursements, increasing regulations, the cost of installing electronic health record (EHR) systems, and worries that shifting referral patterns will exclude them.

Scott Gottlieb, MD, Resident Fellow at the American Enterprise Institute, a conservative think tank in Washington, DC, said that hospitals buying physicians' practices is bad for both sides, because physicians will work less as paid employees and hospitals will reduce their pay to match the lower productivity.

Dr. Gottlieb recalled that hospitals went on a practice-acquisition spree in the 1990s, but it imploded because they couldn't manage outpatient care and lost a lot of money. Spun off by the hospitals, these physicians quickly returned to private practice. This time around, however, Dr. Gottlieb said that any physicians who were spun-off would have a harder time restarting their private practices. Reimbursements are lower than in the 1990s and it's harder to get bank loans.

His advice: "Resist being consolidated as long as you can. Buy yourself some time." And if you do need the protection of a larger entity, Dr. Gottlieb suggested joining an independent practice association (IPA) instead, though he conceded that it might be more difficult to find IPAs in parts of the Northeast and Midwest.

La Penna suggested that small practices form loose information-sharing collaborations. Each practice manager could become an expert on a certain topic. They could also share very basic market intelligence. With rapid changes in the market under way, "it is essential that physicians know what is going on in their community," La Penna said.

New Payment Methods May Zap Fee-for-Service

The ACA has built upon a new trend that is replacing straight fee-for-service payments with new payment methodologies based on outcomes, such as bundled payments, patient-centered medical homes, and shared savings in ACOs.

Although the new federally recognized ACOs and the government's Center for Medicare & Medicaid Innovation are taking their first cautious steps with new payment methodologies, many commercial payers are moving ahead at a fast clip, according to Keegan, the North Carolina consultant.

She pointed to Cigna's collaborative accountable care (CAC) program with primary care providers, which is using "care coordinators" — CAC-paid nurses who make sure that patients are getting follow-up care. Cigna runs 28 patient-centered initiatives in 17 states, involving more than 4000 physicians.[8]

Keegan said that practices should take advantage of the extra funds and services that payers are currently offering in such programs, because they may not last. For example, as physicians become more efficient in shared savings programs in ACOs, the base payment rate will decline.

She warned, however, that the transition from fee-for-service to new payments might be bumpy. During the next 5 years, "physicians will be living in 2 worlds" — fee-for-service and the new payments — "and it will be very, very confusing," she said. "Your whole revenue cycle gets affected."

The new payment methodologies also require sophisticated IT systems, a great deal of data-reporting, and shared networks, according to Dr. Walton at the Genesis IPA.

He said that physicians have to go through "a cultural transformation" to deal with the new methodologies. "They have to learn how to work in a team and share clinical decisions with other caregivers," he said.

Genesis, which is applying to start a Medicare ACO, is asking its physicians to engage patients through new technologies, such as text messaging and email. "You don't have to be face-to-face to ask a question," Dr. Walton said. "In fact, the new reimbursement system will not reward you for a face-to-face visit."

Rising Penalties Will Reduce Reimbursements

As the ACA is further implemented, the Centers for Medicare & Medicaid Services (CMS) is beginning to reduce payments to practices that do not comply with various CMS initiatives.

In 2012, CMS started imposing a penalty on physicians who do not meet e-prescribing (eRX) levels.[9] The eRX penalty started in 2012 at 1% and increases to 2% in 2014. In 2015, CMS will begin imposing penalties for not complying with EHR implementation standards, following up on "meaningful use" incentive payments for EHRs.

Also in 2015, CMS will begin levying penalties based on its Physician Quality Reporting System (PQRS), in which physicians report quality measures that they select from a CMS list.

Right now, Keegan said, the penalties do not exceed 1.5%, which is still relatively low on a practice's pain scale. But when the PQRS and EHR penalties begin in 2015, physicians could receive a maximum total fine of 4.5%, which would rise to 6% in 2016 and 7% in 2017. Those levels would have a significant impact on practices, Keegan said.

The PQRS penalty follows up on a voluntary reporting program that most practices did not participate in. A CMS report found that only 1 in 5 physicians and other eligible health professionals reported PQRS quality measures to CMS in 2009, and only a little over half of those participants scored well enough to receive an incentive payment.[10]

Physicians will also be affected by value-based modifiers in 2015. Those who will feel the impact have already begun receiving previews of their scores. "These numbers can help physicians prepare," Keegan said. "This is a great opportunity for higher payments down the road."

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What's New at NEJM?

Physician Passive Jobseeker Study

The NEJM CareerCenter recently commissioned Digital Research Inc., (DRI) to conduct a blind study of physicians in the United States to gauge their different levels of job-seeking activities. This study reveals that approximately 77–86% of the physician population are passive jobseekers.

Summary of the key findings will be released as a white paper. It will profile the passive jobseekers: learn where they work, who they work for, years in practice, job satisfaction levels, and how both the passive and actives behave around job-seeking activities!

Understanding the passive jobseeker is key in order to reach the largest pool of candidates. The white paper can be downloaded at www.NEJMCareerCenter.org/passive.