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Top Five Trends for Medical Groups: What Health System Boards Must Know About the Changing Physician Environment

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For healthcare organizations, this will be the year of investment in the physician environment. Acquisitions of physician practices and medical groups will continue but are expected at a slower rate and in general are not producing the financial results anticipated. We predict a greater focus this year on revenue-generating opportunities, revenue cycle management, core operational performance initiatives, and digital health advancements to meet evolving consumer demands. The following five trends for medical groups will help governing boards understand the challenges, opportunities, priorities, and concerns affecting both employed and independent physicians. Boards should look for ways to ensure that their strategic plans and priorities address these essential market dynamics.

Takeaways and Questions to Consider in the Boardroom

- What is our system strategy regarding future physician alignment, employment, and deployment (expand, maintain, contract)?
- What is our digital health strategy and how are we changing physician workflows to incorporate new technologies and tools?
- Are we engaging and empowering physicians as "partners" to more assertively improve quality and patient experience while managing costs and reducing clinical variation?
- Are we taking advantage of new Medicare, Medicaid, and other payer incentives that may reimburse and reward for qualifying primary care services in areas such as virtual visit check-in, remote evaluation via video/imaging, incenting healthy behaviors, and others?
- Are we extending our primary care reach into the communities we serve to address social determinants of health and other factors in the local environments?
- Do we have a process to proactively identify and address physician burnout?

1. Manage Practice Acquisitions and Expectations

Physician alignment remains a top priority for health systems, resulting in an influx of employed and networked physicians. With continued focus on acquisitions of targeted high-value providers, limited time was invested in operational performance and strategies to ensure financial returns. As a result, the cost of acquisitions from years past are starting to weigh heavily on senior leadership. But the pain is not spread equally across the market. Private equity firms have acquired well-regarded practices such as dermatology, orthopedics, and gastroenterology. The goal of private equity being to invest in the practices and sell them for an increased profit or roll them into a powerful delivery network in a market. To realize those gains, equity partners are offering physicians a 20–40 percent ownership in the practice in exchange for a practice revamp that yields annual returns of 20 percent or more.

Board to dos: Take a page from the private equity playbook. Health systems need to recognize that returns from physician practices are possible, but not without heavy lifting. Hard decisions must be made to modify workflows, adjust provider and support staffing, change leadership teams, effectively manage revenue cycle, and capture new revenue streams. If physicians understand these expectations from the onset, it's much easier to overhaul operations to achieve

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desired outcomes. Physician practices do not manage themselves and require experienced leaders and tough decision making to remain relevant.

2. Reduce Administrative Burden and Optimize Revenue

Physician burnout continues to be a pervasive issue, with 56 percent of physicians surveyed by Medscape citing increased bureaucratic tasks such as charting and paperwork as their major pain points.[1] CMS is addressing these and other physician issues with changes to the physician fee schedule (PFS). The recently published final rule of January 1, 2019, simplifies documentation requirements, eliminates duplicative tasks, and generally abates many of the administrative burdens of compliance including duplicative entry of information into the medical record such as chief complaint and history. In addition, the rule provides new payments for some technology-based services, such as virtual visit check-in (HCPCS G2012) and remote evaluation via video/imaging (HCPCS G2010).[2]

Board to dos: Follow the recent and future expected changes in the PFS, MACRA, and other value-based reimbursement models, and educate physicians on the changing rules. Implement new care models to reduce the administrative burden, allowing more time for clinical care and improved work/life balance.

Understand the financial impact and implement new virtual visit codes to obtain payment for services already provided. For example, a group of 100 physicians that each provide two G2012 services per day for an estimated 260 clinical contact days per year would yield more than $760,000 per year. Remember this is for direct patient contact, a service that many physicians are already providing their patients at no charge.

3. Be Mindful of Digital Health Opportunities and Market Disruptors

Telehealth is growing at an ever-expanding rate, with significant inroads being made at the federal and state levels to fund these services. According to BCC Research, telehealth makes up one-fourth of the healthcare-related technology market, and is predicted to be valued at $20 billion by 2019.[3] A report by Circle Square Inc. states that well-funded innovators in the telehealth space, American Well, Teledoc, and MDLIVE are on course to disrupt the urgent/convenient clinic market.[4] The report also predicts a rise in chronic disease/condition-specific apps and wearables such as Flatiron (oncology), Livongo (diabetes), iRhythm (cardiology), and Propeller (asthma). PillPack, an on-demand home delivery service recently acquired by Amazon, has the potential to disrupt the medication compliance segment. At the same time, early adopters of Apple's Health Record implementation are receiving positive feedback from patients on ease of use. Apple Health Record allows patients to easily access and share their health information using their mobile device, with the goal of improving coordination of care and health outcomes.

Board to dos: Make sure you have a comprehensive digital health and social media strategy that integrates with your reimbursement methodologies and is tailored to your population and patient needs. Think about how to engage, monitor, and interact with patients virtually, and create new operational workflows to support these new modalities. Evaluate new and developing digital health solutions to see if they are a fit for your consumer base to manage high-risk or other identified populations.

4. Focus on Primary Care Transformation and Patient Engagement

Expect to see a greater focus on patient engagement programs, health literacy initiatives, emotional health offerings, and patient incentives with the aim of helping patients self-manage their conditions. Modern primary care centers are using data-driven, real-time tools for decision making. They are putting patients at the center of their care and extending their reach into the community, acknowledging that health outcomes are significantly influenced by social determinants of health and other factors in the local environment. Successful health systems are transforming primary care as a means of managing healthcare costs and reducing unnecessary or preventable specialty or hospital utilization. In addition, organizations are looking to financial incentives to improve patient compliance in preventative care. There is strong evidence that financial incentives, particularly for vulnerable populations, increases patient use of

1 Carol Peckham, *National Physician Burnout and Depression Report* 2018, Medscape.
2 Centers for Medicare and Medicaid Services (CMS), Physician Fee Schedule Final Rule, January 1, 2019.
3 Steve Cumming, "Wearable Electronic Devices Rapidly Gaining Ground in Healthcare Information Technology Industry," BCC Research, May 2015.
4 Circle Square Inc., *Digital Health Trends*, December 2018.

primary care, including screenings and vaccinations.[5]

The Medicare Shared Savings Program's new guidelines for 2019 allow some downside risk models to implement a beneficiary incentive program to reward assigned members $20 for each qualifying primary care service. Further, state Medicaid programs are providing financial incentives to incent healthy behaviors. In the private market, emotional and behavioral digital health solutions are growing in popularity. According to Sensor Tower, the top 10 self-help apps grossed $15 million in revenue in Q1 of 2018, a 170 percent increase over Q1 of 2017.[6] Emotional health, self-help, and addiction apps such as Calm, Noom, Habit, and DynamiCare Health are rapidly enticing investors, as are independent solutions for care management and population health.

Board to dos: Evaluate opportunities (i.e., social media, patient portal, self-help/disease-specific health apps) to further engage patients in self-management and look for opportunities to take advantage of payer incentives to tackle compliance. Transform primary care practices utilizing technologically enabled clinical models (i.e., virtual visits, wearables, data-driven analytics) combining physical, social, and behavioral modalities, along with consumer engagement and financial incentives to affect health outcomes. Take a holistic approach to primary care, understanding that an upfront investment in an effective primary care strategy will lower healthcare costs in the long-term.

5 Cathy Bradley and David Neumark, "Small Cash Incentives Can Encourage Primary Care Visits by Low-Income People with New Health Care Coverage," *Health Affairs*, Vol. 36, No 8, August 2017.
6 Sensor Tower, "Top Grossing Health & Fitness Apps for 2018," January 7, 2019.

5. Manage Access to Care to Prevent Overutilization

Establishing access points, including retail clinics, urgent/convenient care clinics, and virtual visits has been a dominating theme recently, and may be tipping the supply/demand equilibrium. It is now estimated that consumers are taking advantage of these alternative sites of care in record numbers. But with few processes in place to effectively manage overutilization, these new access points are driving up costs. Furthermore, at the end of 2017, Medicare Advantage enrollment was at 20 million and is on trend to double that number by 2025.[7] UnitedHealthcare and Humana, both significant players in the Medicare Advantage space, have exceeded earnings reports this past year largely due to their success in managing Medicare Advantage patients.

7 Bill Frack, Andrew Garibaldi, and Andrew Kadar, "Why Medicare Advantage Is Marching Toward 70% Penetration," *Executive Insights*, Volume XIX, Issue 69, L.E.K. Consulting, 2017.

Board to dos: Understand your patient population to determine what types of services and resources need to be adopted to best suit members in particular markets. Focus on your primary care strategy and learn how to manage discrete populations such as Medicare Advantage patients successfully and create focused programs for those members. Track visits/patients by access point. Evaluate enabling technology and deploy strategically. Rethink workflows and access points—utilize virtual check-in visits to monitor patients in lieu of an office visit and integrate urgent care and retail clinic visits into your primary care model. Remember that a one-size-fits-all model does not work in the outpatient space. While many patients are technologically savvy and anxious for virtual visits, others desire and require a more hands-on approach and intervention.

Moving Forward

Change in the physician practice continues to accelerate with digital technology fundamentally altering the way consumers access and utilize care. It is essential that health systems think creatively, innovate often, and create highly adaptive, connected care sites to meet consumer demands and stay ahead of the curve.

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