In this episode of AMA Thriving in Private Practice, the conversation continues with Mike Grodus, chief administrative officer at Professional Medical Corporation, a Physician Health Organization (PHO). He addresses recent trends in commercial payer contracts such as “value-based” contracts, cost and quality provisions and telehealth adoption.

Also discussed, the AMA’s recent work and overall thoughts on innovative contracting opportunities and advantages for private practices and PHOs.

Listen to the first part of the conversation.

Speaker

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Host

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Transcript

**Vargo:** Hello and welcome back to AMA Thriving in Private Practice. Here with me again today is Mike Grodus from Professional Medical Corporation. Mike is the director of health care transformation at PMC and has a wealth of knowledge to offer on contracts for private practices, as we heard on our last
episode. If you missed it, I'd encourage you to go back and give it a listen. Today, we're going to pick up that conversation. Good to speak with you again, Mike.

Grodus: Oh, likewise. It was great. Look forward to our session here and taking a little bit deeper dive onto some of the topics here.

Vargo: Exactly. To pick back up on those threads of the first discussion, can you briefly refresh our listeners on the work that you do and how you're supporting physicians in your physician organization?

Grodus: Sure. Again, looking at Professional Medical Corporation, our physician organization, where we have mostly independent physicians coming underneath a corporate structure to really organize and a way to maximize opportunities and contractual arrangements with the payers. The work that we do with our background is really setting up our organization and running the physician organization in a way where we have competencies that allow us to really maximize opportunities for incentives.

As physicians who are out there being independent want to remain independent, they really rely on additional income into their practice. This is not so much as, "Oh, here are some extra funds," but really a major part of sustaining their independence is the ability to be in an organization that allows for the opportunity and actually generate some of these incentives. The work we do is really ... It's as simple as looking to find ways to maximize incentives for our independent physicians to keep them independent.

Vargo: In our previous conversation, we talked about some terms with regards to contracting. Specifically, we talked about value-based contract or often interchangeably risk-based contracts. Can you dig into some of those specifics around that for our audience?

Grodus: Oh, absolutely. One of the foundational pieces, we talked last time considerably about what it takes to form a physician organization and have a highly effective organization. But the key foundational piece of really why you bring physicians together are contracting with health plans, so bringing our physicians together to really leverage the ability to get the best contracts with the payers. If you don't have the right contracts in place and know your market and know your payers and know who you're dealing with and have the ability to negotiate the best deals, you could be in these contracts and still not reap the rewards or really not maximize the opportunities within the different programs. There are a lot. Again, contracting and the contracts that a physician organization have, are major key piece to the success of the PO. There are a number of contracts like we mentioned last time.

With the different payers, they generally have a commercial product, a Medicare Advantage and a Medicaid. The importance of understanding is each one of those programs have different parameters for negotiating the best deals. There are different things in a Medicare Advantage that you can
negotiate versus a Medicaid versus a commercial. You really have to understand the different products that are out there.

If you move along the continuum of the value-based contract, which really just means, yes, you have your fee for service. Somebody comes in for an office visit, here's your $100. Oh, now I have an opportunity if I manage a patient correctly, meet the certain parameters or goals that are set forth in this contract between the payer and our group, you can earn additional dollars.

There are programs and terms that when you move from this fee for service, past human quality into total cost of care arrangements that you generally see out there, percentage of premium really means like you're looking at a program whereby you have a certain amount of revenue that the health plan allocates towards the taking care of their members. They get a premium. You get a percentage of that. It's like a little mini P&L that they put forth. They don't give you all that money but they track it.

Here's the money to manage your expenses. If you manage your expenses and do it underneath the revenue, you have a gain and there are different sharing mechanisms. There's also something called medical loss ratio models, which are a percentage of expenses to the actual revenue that is generated. Same concept. For those who are new to this, you may be thinking, "Oh my gosh, what are those terms?"

But I just wanted to put it out there because you may hear these terms come up in your discussions as you move forward or they're even medical expense targets. Some health plans have just, "Here's your expense target. If you beat the target when you add up all the expense of this membership within your certain program, you have gains." Now, within each one of those type of foundational pieces, how they set up their programs, you can have upside only. You could have upside and downside.

As we talked last time, there really is a move for the payers to get into the area of shifting risk down to the physician organization, to the doctors. But when you start out, you can negotiate contracts as you're getting going that gives you a piece of the pie in what are called upside-only contracts, whereby yes, you have this either percentage of premium, or medical loss ratio model or expense target.

Bottom line, if you make money out of those programs, they will give you a portion of the savings, and it's shared between the health plan and the physicians. Generally, when you're in the upside only, meaning, okay, if you don't hit your target, they're not going to come looking for some money from you to pay that back. You just have an opportunity for a gain share if there is a positive outcome within the program.

Vargo: Yeah, so Mike, because we are talking about a lot of complex contracting expectations from plans and from what we're seeing now. Just to underscore, I think that in this value-based world, there has been a spectrum, correct? Where you've just noted many folks have been getting into these "value-based contracts" with upside-only as a way to get providers, physicians, others, hospitals
comfortable with this notion of just looking at the total care of a patient, right?

**Grodus**: That's correct, yes.

**Vargo**: Physicians always ask and the AMA has done a RAND study about this, what does value-based contracting mean? I think it's important to highlight that at the end of the day, I think people are approaching this as a goal of trying to improve the overall value, which is the equation around cost and quality, right?

**Grodus**: Correct.

**Vargo**: It isn't just correct lowering costs. I don't want to lose that thread of the importance about value in terms of quality because we're going to be getting to some of that when we talk about quality metrics. But I think it's important to really remind folks about what's the goal of all of this. Because otherwise, why are health plans asking physicians to take on more risk? Which you may agree with or may not.

But I think from a PO perspective, what are your thoughts about the real benefits of maybe being in a risk-based contract to potentially deliver higher quality care? I'm just curious on your thoughts there.

**Grodus**: Oh sure, yeah. The health plans are very highly motivated to engage with physicians. Because as we all know in the health insurance world, premiums are going up for customers. If you're an employer, the health plans always struggle with, how am I going to stop this trend? Every year there's a medical expense trend, a utilization trend that goes up. It could be five, six, 7%. In order to cover those expenses, the health plan is looking, "I can't keep raising my premium to my customers, to these employers. They, number one, can't afford it. And number two, I'll lose their business." They are really motivated to look at taking care of their membership, like you indicated, in a very effective way, certainly giving them the right care. There is a lot of waste in the system that can be corrected that will cut costs out. Yes, you're absolutely right about quality. Yes, the health plans are motivated to work with groups and make them more accountable because they feel they'll be more motivated to actually take the necessary steps to more effectively manage those patients in a very effective and quality-driven way.

**Vargo**: Again, we've talked about this trend with employers and health plans seeking more risk-based contracting on this notion that that is the solution to potentially hopefully improving quality while lowering costs. Many physicians, however, are not yet ready to assume financial risk. I would advise them that they should not be entering risk-based contracts unless they have some key components, some key knowledge in their wheelhouse.

From your perspective, what do physician practices have to have in place to successfully entertain assuming a risk-based contract?
Grodus: I think it would be something that in order to even be offered, one, you would have to have some kind of organizational structure, or you may not even have the opportunity, as we talked about, having kind of a one-off contract with a health plan. That being said, you would find an organization or other physicians that you have with common goals and common motivation to really engage in managing the patients. We certainly see a spectrum of physicians.

Some are better at managing their patient than others. Some are more motivated than others. But the key we find an organization that aligns that does have the infrastructure. What do you look for? You look for a foundational piece where they do have contracts with health plans. They have the ability to have some of these upside-only agreements as they're just jumping into things, so they don't have that downside exposure.

Once they do start getting some downside, there are ways that money can be retained by health plans where it's not going to be, "Here, hand me a check." There are some usually smaller downsides that are associated with that. Having a PO that will support you and your technology and set aside strategic funding to really encourage the use of your electronic medical records, which really help you manage a patient, get information out, help you kind of close the quality gaps from information with the health plans that you're passing back to them.

And also have a team of professionals who have experiences, who have had proven success. Again, mentioning infrastructure that you do have. Not only is technology but you have folks who can go out into the practices on a routine basis, bring these reports out, bring reports that show them exactly what they need to do. Train them. Train their staff. Keep rounding with them on a monthly basis. All these programs change. They vary. They have to be up to speed.

They have to know in their very, very busy practice, "Oh, here's the list I need to focus on. It's disseminated down here. Work on these 25 patients to bring them into the office," because you need a visit to take care of them in a way that, again, will manage according to some of the contractual provisions that allow the incentives to be triggered. It really is having an organization that can educate, could train, that's kind of walking in lockstep that allow them to understand what their exposure is, what it's not, being very transparent.

There are many organizations we find here, even in our market, we have physicians jumping into our organization going, "Oh my gosh, I didn't even know what the contract was, or how much I would've owed or how much I gained." Being very transparent that, "Oh, we've had a gain. Here's a distribution methodology to the physicians that will be very straightforward and fair."

I mean, committees that can go and actually kind of go through that, vote on that, and have a very formal transparent way of doing business.
Vargo: Yeah. I think the keywords that you highlighted were absolutely what I would say a takeaway is that culture of working together and understanding what the values are—the infrastructure—so the technology, the EHR capabilities, the care coordination, tracking and monitoring, which is quite a lot. I’m sure you know better than I. If you’re managing across 10 different payers, then I can only imagine they all have different measures and they’re looking for different things, which really gets into this notion of the burden. What’s the burden on the practice to do this and to do it well? My takeaway from this conversation is that there are some key components that need to be in place for a practice to assume risk in a contract. Really you need that culture that’s committed to managing costs effectively, striving towards potentially improving quality based on quality metrics.

You also need the infrastructure that goes with that, so clearly an electronic health record, the tracking and monitoring of the care collaboration. And then I also think you have to be able to financially manage all those dollars coming in with that risk. To me, this all sounds quite potentially administratively burdensome. Talk a bit about that burden and how that is managed from your PO’s perspective?

Grodus: It is going to require additional work on a physician level. And that’s where we do really struggle with our physicians who are so burdened with their patient loads. Certainly, COVID was here and they’re going, “Oh my gosh! I mean, 15 value-based programs. When you add up the other programs, we may have an excess over 25. How do I keep all this straight? I got to see my patients.” What we try and do is... With our team, and we call them practice consultants, the ones who are actually going out to the practice.

We have a manager over that area. We also have an operations person that could help form out some efficiencies. We look to find ways to condense all these different 15 programs down to kind of a very concise meeting with physician. Because when we’re asking to get into their office on a monthly basis and take an hour of their time, sometimes it’s very difficult for them to remove themselves. But yes, it is definitely on their staff and on them.

There are things that they have to realize that they need to undertake to be successful in the program. The way that we try and minimize that, there is extra work, is to every meeting we have with them to make sure there’s value add, that we’re very concise in the delivery of what exactly they need to do. Even getting down to, "Here’s the system you need to go and here’s the report you need to look at. Here’s your patient list. Here’s the follow-up that’s out next month. Let’s talk through that."

There are ways you have through your structure that takes a lot of the burden off but there still are many things physician has to do and it is additional work on their behalf.

Vargo: It sounds like one of the benefits of forming the PO, is that there are full-time professional staff employed by the PO, paid for through the organization and the physicians participating in the organization that are really assuming some of these administrative tasks, the quality reporting
analysis. It's not just negotiating the contracts, which is what you're doing, but there's also staff there
to provide all this other important support that's needed to be successful in those contracts.

**Grodus:** That is absolutely correct. You said it very well. I only stress the importance of the
foundational piece of the contracts. Because if you don't have the right things in place, and I know
there's multiillions of dollars left on the table, that if you don't have somebody who understands how
to negotiate and what the market's like, you'll be leaving on the table. With that, again, being said,
yeah, there are ways to mitigate some of the burden.

Again, there is staff that is part of the PO, that when you start earning incentives or you get some
upfront money, you do have to support yourself. The health plans here in our market recognize the
infrastructure, and that is the staff, exactly like you said, that goes out and takes care of the
physicians. We're even getting into not even just managing the contracts, which we do a very good job
at in terms of earning incentives but we have our leadership saying, "I know you're doing this, but we
have pain points in our practice."

The PO we've actually gotten into an area were, "What are the pain points?" "Oh my gosh. Some of
the EHRs, electronic medical record systems, they have, working with the vendors, where you put the
information." We actually have an individual that goes around and practices helping them answer
questions with their EHR or if there are certain things they need, a patient list call for a certain
Medicaid population that has to come in, we'll assist with some of that or even quality entry into one of
the health plan systems or the forms that a health plan requires.

We are trying to go an extra level and step, and that's what a PO can do for you to take away some of
the burden and the pain points not even related to specifically some of the main work that you do
regarding the contracts.

**Vargo:** Yes. That is such an important component, I think, of what your organization and other POs or
IPAs do is provide that level of administrative support. Because as we noted at the beginning of our
series here with you, care is so complex these days and managing contracts and multiple contracts
against multiple payers because then, unfortunately, there isn't a lot of alignment among those
contracts.

It's just really that burden that I think is very overwhelming when a physician thinks about even
entering into a private practice arrangement. It is great to know that POs are out there as an option.
I'm going to touch on a point that actually adds more complexity potentially to this already complex
environment, which is telehealth. We know obviously during the pandemic, telehealth became a
lifeline for practices there's been rapid adoption of it.

But tell me about that piece of the puzzle with regards to adoption of telehealth and the PO? What is
that looking like? What are you hearing from commercial plans with regards to contracting around the

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use of telehealth?

**Grodus:** Yes, and we've seen so much change. Before COVID hit, telehealth was very, very minor. I think the evolution really escalated and got put on a fast track, a couple years back. The health plans were very good about recognizing the need then for telehealth.

They really modified some of their rules regarding which patients, members can have telehealth, what you can accomplish through a telehealth visit, adding codes that are billable, compensating physicians at a level they made have directly as if somebody was coming into the office versus a reduced rate. Health plans have been great in terms of communicating, trying to add codes, trying to modify to the way that the physicians needed to practice via telehealth. Again, as a PO, we really assisted.

We have a number of resources that understand telehealth and actually work with a number of our practice to aid them and assist them into getting the technology and understanding the technology and how to get set up for telehealth. And then certainly all the rules that were coming from the 10 different health plans we contract with, us making sure they understood what those were so their biller could bill the appropriate code, so they could still get paid to keep their practice running during that time.

Yes, much more in that space. It really escalated. Now, most of our physicians are doing telehealth. They're actually maintaining that even now as some patients want that. That has really taken a turn in a positive direction, both the ability to do that, the technology, physician and patient comfort level, and the health plans recognizing and compensating for that.

**Vargo:** Do you think that the long-term coverage of telehealth from the health plans will be retained? Because I know during COVID, there were parity and I think in certain markets that may be going backwards. What's your sense? How can the role of a PO take place in terms of ensuring that there is continued adequate reimbursement for a telehealth visit versus an in-person visit?

**Grodus:** I think that although you may have a payer or two that want to do some reversion back, most of them recognize now the importance and that's kind of the new way of life. If there are certain codes or circumstances though that our physicians feeling, "Well, I'm on the phone but I don't see a reimbursable code or I'm not sure can I bill for this," as a PO, part of the administrative job is to be the liaison with the health plan where we have meetings with all our health plans basically on a monthly or quarterly basis called joint operating committees, whereby we have contacts there that we on behalf of our physicians take their issues, two.

One being if they need a telehealth code reimbursed or it's not being reimbursed appropriately, we get to the level in the organization of a health plan where they will take it to their leadership, assess it, knowing probably we're not the only ones asking for that but we will press very hard to get some of the changes made and a PO can make a difference in that. We have made a difference working with health plans to accommodate our physicians.
Vargo: That is great and good to know. I think we're, unfortunately, going to have to wrap up our session because this has been so fascinating and so much information. Again, encourage our listeners to go back and listen to the first session with Mike, which was really foundational to some of this conversation.

As we move to closure today, Mike, and again, thank you so much for your time, maybe if you could recap for us sort of the big key takeaways that we've talked about in our two conversations around the importance of the role of a PO or an IPA to allow individual private practice physicians to be participants in these key trends going forward with regards to and provision of high-quality care.

Grodus: Sure. Just as if you think about the CMS, ACOs and what they were trying to do now for a number of years and look at sharing costs with physicians, the health plans or the payers we know are moving in that direction. That's not going to stop. It is going to continue to escalate in terms of the better part of your reimbursement, maybe coming from these incentive programs.

It will be in a movement that those who can perform well and do well will be grabbing bigger pieces of the pie in the incentive world as the incentive programs change for the physicians not only to just jump into them and get paid that way but actually take some of the downside risks. As we know, it's moving that direction and health plans are pressing hard. We don't see it going back. It is important as we indicated to make sure you understand your market, what health plans and payers actually pay for.

Do they do contracts with POs? Do you have POs in your market or PHOs that you can start talking to, to connect with if you're an independent doctor wanting to join because there are bigger opportunities if you can get yourself in a physician organization. Also, you have to pick the right physician organization. In our market, there's 40 across the state and three even in our direct market. Physicians do have an option.

You have to make sure you, as a physician, are selecting and almost interviewing the POs to understand, “Are you transparent? What kind of deals do you have? What's your reimbursement structure? How do you treat your physicians?” Again, the importance of understanding which PO you're joining is very important as well.

Vargo: Competition is important in these markets, even among physician organizations, which is really good to know. Michigan may be unique in that level and that penetration in the market. But I think this is why we really wanted to bring you to the conversation, Mike, just because you have such great experience in this field.

We really appreciate you taking time out of your busy day for all the work that you're doing on behalf of the physicians in your PO in Michigan and sharing your expertise with our listeners today.

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Grodus: Oh great. It was a pleasure speaking with you and being able to share. Again, it's for the common good. We know there are independent physicians wanting to remain independent. Really the message I like to leave them with, there is opportunity. There are opportunities. There is hope. Don't feel defeated. You will find a path. You'll find a way, and you have opportunities to remain independent and still do well and keep your practice that way.

Vargo: I could not have said it better. Thank you so much.

Grodus: All right. Well, great talking with you, and thanks again for the opportunity to share information today.

Vargo: Great. You can find the AMA's contracting resources that we've touched upon in today's conversation, including our resources on value-based contracting at the [AMA website]. I'm Carol Vargo, and until next time, this has been Thriving in Private Practice. Thank you so much for listening.

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