

Evaluating and Restructuring Your Systems

Chapter FastFACTS

- 1. Practices that lack the resources to go electronic may consider gaining that capability by aligning with hospitals and health systems.**
- 2. The ACA calls for experiments and demonstrations of all types of ACOs, not just those led by hospitals.**
- 3. Physicians can enhance coordination of care by having their practice become a medical home or asking specialists to include them in decisions.**
- 4. Medicare's Patient Quality Reporting System will become mandatory under health reform.**
- 5. Consultants recommend that physicians track and report on their quality even if they don't have an electronic record.**

Health reform is prompting medical practices to take a close look at their practices and ask, “Can we do it?” Can a practice’s systems—from information technology, staffing, access, and quality of care—serve in a new healthcare world order? Ask yourself the following key questions to help guide your restructuring efforts:

- Do you have an EHR and can you use it in a meaningful way?
- Can you cope with an influx of newly insured patients?
- Can you coordinate care and share risk?
- Can you meet expanded quality reporting requirements? Do you understand continuous quality improvement?

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- Can you be a leader during this period of change? How well do you cope with change?

In addition, be aware of changes that can affect your day-to-day business operations (see “How to Prepare: Avoiding Fraud and Abuse” and “How to Prepare: New IRS Rules”).



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J. Fred Ralston, Jr., MD

Internist

Fayetteville, Tenn.

President

American College of Physicians

Health Information Technology

Richard M. Dupee, MD, a general internist and geriatrician in Wellesley Hills, Mass., recently invested \$100,000 and weeks of his time in implementing a new EHR. He recognizes that there are practical reasons to make EHR installation your top restructuring priority: In the near future you won’t be able to file a claim, prescribe, or receive a lab result if you don’t do it electronically. “We are fully expecting to get money from Uncle Sam for [having an EHR] sometime this year. And Medicare isn’t going to pay you if you don’t have one later,” he says.

That means now is the time to bite the bullet by investing in and using IT: the government’s incentive programs (part of the HITECH portion of the American Recovery and Reinvestment Act of 2009, commonly known as the stimulus bill) will pay Medicare and Medicaid providers only until 2014 (under the Medicare incentive program) or until 2021 (under the Medicaid incentive program); and most practice consultants say you may as well get paid to do what you’ll need to do anyway.

Practices that lack the capability or resources to go electronic can consider aligning with hospitals and health systems that are

seeking greater integration with primary care physicians. Mr. Thomas advises caution but acknowledges the potential in leveraging “someone else’s financial infrastructure to participate in the future of HIT: You might get much more than you could get on your own” while positioning yourself to be in the forefront of a start-up ACO. There is an explicit Stark anti-kickback exception, in fact, that allows hospitals to help physicians not financially aligned with hospitals to buy computer software.

Handling More Patients

If you had to see one more new patient every day, how could you do it? Would you have to pay overtime? Give up lunch? How would it affect your practice’s schedule?

For some physicians, depending on their specialty and geography, the added volume of patients due to health reform may mean one or two new patients a day; for others, it may mean a surge—one that could include an older, sicker population. Therefore, practices are going to need to run as efficiently as possible. “Increasing [patient] volume is definitely going to be a problem,” Mr. Hertz says. There is a limit to how many [patients physicians] can see and be effective.” As a result, it’s critical that staff members work to the top of their license or the top of their ability. Are physicians spending their time checking medication lists when nurses could perform that task? Are nurse practitioners taking routine blood pressures when MAs could do that? Are MAs putting patients in rooms when receptionists could do that? Are receptionists making routine reminder calls that could be handled by an automatic computer program? Staffing issues will come into play as well to meet health reform’s financial incentives to provide additional education, care management, and case management.

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How to Prepare: Avoiding Fraud and Abuse

The ACA contains a plethora of new healthcare fraud-and-abuse rules backed by an additional \$350 million in funding for enforcement.

One such rule allows the government to go after physicians who don't report and refund "overpayments" in a timely manner. The law redefines such unreported and unrefunded "overpayments" as "false claims": "If you violate the False Claims Act by submitting a claim that you know is false to the federal government, you incur significant penalties and possibly criminal prosecution, whereas an overpayment is just an overpayment," explains Joyce McLaughlin, JD, a health attorney with Davis & Wilkerson in Austin, Tex. Before this change in the law, "You would send it back if you found it and nobody thought much about it. And I don't think most people even looked for them very much. Most people were more concerned about finding underpayments."

But now, she says, it is incumbent on doctors to find these overpayments, return the money to the carrier or contractor, and "disclose in writing the reason for the overpayment no later than 60 days from the date you identify it." She recommends that doctors prepare for this change by talking to their billing companies and ensuring that their billing software can check for overpayments regularly—within 60 days after you identify the overpayment. It is still unclear how long the government will consider to be untimely.

A second provision concerns physicians who want to refer patients for an MRI, CT, or PET scan using equipment that they own. These physicians

Coordinate Care and Share Risk

About a year and a half ago, C-Health in Lebanon, Va., started experimenting with group visits for patients with chronic pain, addiction, and uncontrolled diabetes in order to provide more coordinated, efficient healthcare and better outcomes. "It's a mindset shift for the doctor, to think outside the one-on-one visit; but I think we're trying to be open," says S. Hughes Melton, MD, one of the practice's five family physicians. "We're trying to understand there is a better way."

For many independent doctors in small offices, health reform will mean the end of practice as they know it, say many consultants. But it's harder to know and plan for what doctors will need to do to integrate their practices. The ACA does not spell out requirements, but instead encourages experimentation.

must give patients written notice that they can go elsewhere to obtain these scans. The written notice must list five other suppliers within a 25-mile radius of the doctor's office. "They aren't required to have the patient sign anything, but we are recommending that doctors document in patients' charts that notice was given and the patient chooses to have services here," Ms. McLaughlin says.

The ACA also allows the following, all in an attempt to identify potential fraud before it occurs:

- A more rigorous screening program for providers and suppliers, including durable medical equipment suppliers, enrolling in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).
- A new enrollment process for Medicaid and CHIP providers to identify those who have a history of defrauding state or federal governments.
- New predictive modeling software, like that used to detect credit card fraud, to stop trends that may indicate healthcare fraud.
- Permission to stop payments temporarily to providers and suppliers in cases of suspected fraud.

The government has been stepping up its fraud prevention and enforcement efforts over the last several years; and in 2010, HHS recovered \$4 billion, the highest annual amount ever recovered from people charged with attempting to defraud Medicare, Medicaid, and CHIP. A total of 726 people were convicted for healthcare fraud-related crimes in 2010, according to HHS.

Many health policy experts think that health reform will result in most doctors in most markets being employed by a hospital or health system, or at least closely affiliated. Although debatable, many health reform watchers, like business professor Dr. Martin, believe that the day of the solo practitioner in the individual practice is over, because it is not a model that easily fosters coordination of complicated care for patients with chronic diseases or for risk-sharing under new payment models trying to lower healthcare inflation to more sustainable levels. For example, after evaluating her practice's operations in preparation for health reform, Dr. Fincher recently joined nearly 100 other primary care physicians around the metro-Augusta area to become an independent practice association.

Another reason for the rush toward integration is that manag-

How to Prepare: New IRS Rules

As business owners, many physicians will have to comply with the ACA's new mandates on providing health insurance to their employees or pay a financial penalty, but many also will be eligible for a tax credit to help them afford the cost of providing health insurance for employees.

While most of the insurance-purchasing mandates and penalties don't kick in until 2014, the new Health Insurance Tax Credit for small businesses begins now. That tax credit applies to businesses with fewer than 25 workers whose average wages are less than \$50,000 each. The income of the small-business owner is not included in the calculation. Part-time employees are counted using a full-time-equivalent model.

To qualify, companies have to pay at least half of individual coverage costs; and they can take a tax credit of up to 35% of their share of premiums paid since the beginning of the year. The credit increases to 50% in 2014. Detailed information is on the IRS Website: <http://www.irs.gov/newsroom/article/0,,id=223666,00.html>.

The ACA includes other tax changes that could affect doctors as employers providing health insurance benefits to employees:

ing a medical practice has become so complex that most physicians don't want to do it, says healthcare consultant L. Michael Fleischman of GatesMoore in Atlanta. "This generation doesn't ... care to know about balance sheets and personnel law. They aren't that entrepreneurial," he says. Dr. Ralston says recruitment is particularly difficult for small primary care groups in his part of Tennessee, where physician pay tends to be lower than in many other parts of the country. "Right now, the uncertainty of private practice is one of the factors that keep people out of primary care," he says. "I keep hearing people tell me that they can no longer make it in practice, and they are now taking salaried positions somewhere."

As bullish as health reform is on integration, persistent caveats abound. First, there's the real concern that large organizations are often less nimble and creative than small ones, which is partly why the ACA specifically calls for experiments and demonstrations of all types of ACOs, not just ones led by hospitals. The history of hospitals' buying physician groups hasn't been entirely positive. Many physicians who sold their practices

- Starting in 2014, even though there is no employer mandate per se, most employers of more than 50 full-time employees who do not offer coverage will be assessed penalties of \$2,000 multiplied by the number of full-time employees beyond 30.
- Starting in 2018, employers who provide high-cost plans will have to pay an excise tax equal to 40% of the value of the plan that exceeds the threshold amount (now set at \$10,200 for individual coverage and \$27,500 for family coverage).
- Starting in 2013, the Medicare Part A payroll tax will increase by 0.9% on high-income workers (those earning more than \$200,000); and an additional 3.8% Medicare tax will be imposed on net investment income from interest, dividends, annuities, royalties, rents, and taxable net gain for high-income individuals.
- Starting in 2013, the threshold for itemizing unreimbursed medical expenses on tax returns will increase to 10% from 7.5%.
- Starting in 2013, flexible savings accounts are capped at \$2,500; and starting this year, taxes on distributions from health savings accounts rise to 20%.

to hospitals in the 1990s didn't see promised benefits, nor did the hospitals. Many believe the same cost savings and quality improvement can happen in small organizations as in large ones, particularly if practices transform themselves into medical homes or groups-without-walls that can share employees, IT, and guidelines to improve quality.

Simply because organizations are large and integrated doesn't mean they will invest in the computer systems and collect and analyze the proper data to be able to manage risk. "The mistakes of the past [the many failures in the 1990s of capitation] were based on two phenomena: physicians' groups accepting risk in the absence of understanding the risks that they were taking, and physicians accepting risks without the tools to manage that risk," Dr. Niloff says. "They need really good systems that include predictive modeling, utilization management tools, ways to identify outlier physician performance and ER frequent-fliers, readmission rates, drug-substitution tools, and all the tools that health plans have historically possessed because they essentially will be acting as health plans."

Since there really is no way small practices can do this alone, “a lot of primary care physicians are looking to affiliate with their hospitals; but they need to weigh their alternatives carefully



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Terry McGeeney, MD, MBA
 President and CEO
 TransforMED
 Leawood, Kan.

and not jump in right away,” Mr. Fleischman says. “They need to ask will the pendulum swing back, as it did in 2000? Will we end up saying that ACOs aren’t working? If so, how do they get out of their arrangements? Is there an escape clause?”

Quality Reporting

Now is the time to learn how to use Medicare’s Patient Quality Reporting System (PQRS, until this year known as PQRI). The program has grown over the last five years to include more than 130 measures. It has also gone from being a voluntary program that physicians could use as a quality improvement program to a system that will become mandatory under health reform.

Beginning in 2015, physicians who do not satisfactorily submit quality data will see their Medicare reimbursements docked by 1.5% (2% the following year). The results will be published on HHS’s “Physician Compare” Website for consumers to consult when choosing physicians. “Everywhere you look, the questions of quality and safety are driving health reform,” Dr. Browne says. “If you as a practice can’t measure not only your processes but your outcomes with equivalent acumen as you measure your finances, you are behind the curve.” And yes, he says, PQRS’s measures still largely relate to processes of care, not outcomes, and therefore may not be the ultimate measure of quality. “But it’s the law. It’s real, and process improvement is ultimately necessary to achieve improvement in outcomes.”

Consultants recommend that physicians perform quality reporting even if they do not have an electronic record. “You don’t need an EHR to do PQRI; but if you don’t do HIT, then do patient registries and identify your patients with certain conditions,” says Martie Ross, JD, with Spencer Healthcare Strategists in Kansas City, Mo. “Put all your diabetics in a patient registry, and create an Excel spreadsheet and have your medical assistant or nurse call people to come in for appointments.”

Facing Up to Reform

Not all physicians agree with the new reform law. “The gloom and doom come from a lack of understanding. But the reality is that the good old days were not that great for primary care,” says Terry McGeeney, MD, MBA, president and CEO of TransformMED, a practice management affiliate of the American Academy of Family Physicians (AAFP).

A poll from Thomson Reuters/HCPlexus, released in mid-January, found physicians overwhelmingly pessimistic about what the ACA means for patients, physicians, and the future of American healthcare. The same poll also found that 45% of physicians did not know what an ACO was, a key feature of the ACA’s effort to transform the nation’s healthcare delivery system.

Many consultants say, therefore, that their number-one piece of advice for physicians to prepare for the changes coming under health reform is to lose the bad attitude. Focusing on the negative, they say, is paralyzing. “I think that the successful practices today are the ones saying this is a big wake-up call,” Mr. Hertz says. “Even if the healthcare reform law gets repealed—and the general sense is that that isn’t going to happen—healthcare change is going to happen.”

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