Facing the Accountable New World

What Medical Groups Need to Do Today

BY LEE FERBER, CPA

In an effort to improve patient care and reduce healthcare costs, commercial insurers, government agencies, and consumers are now demanding greater accountability from medical practices and other healthcare providers. To what can we attribute the sudden pronounced push for accountability? Put simply, with the healthcare sector today accounting for approximately 17 percent of the U.S. economy’s Gross Domestic Product (GDP) and with current estimates projecting this to increase to 20 percent by 2020, this rate of growth is no longer sustainable.

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Private payers are struggling to find ways to reduce healthcare costs as businesses and employers can no longer afford to pay ever-increasing health insurance premiums. Government programs such as Medicare and Medicaid are also under tremendous pressure to reduce overall spending in light of a weak economy, overall budget cuts, and a significant increase in the number of Medicaid beneficiaries expected in 2014 as a result of changes in eligibility.

Drivers of Change

While technology has played a key role in the new world of “accountable” health care, the passage of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or ACA) now can be seen as one of the true forces behind health care’s changing landscape. With the U.S. Supreme Court upholding the constitutionality of the ACA and President Obama’s re-election in 2012, the foundation has been laid for health care to continue to undergo dramatic changes at an even greater pace than before.

Most of ACA’s key provisions, other than those addressing health insurance coverage, focus on improving the quality of care and reducing costs. The adoption of an electronic medical record (EMR) system that meets Meaningful Use (MU) standards, the development of Medicare accountable care organizations (ACOs), and creation of the Center for Medicare and Medicaid Innovation are all key pieces of this legislation. Many of these initiatives are starting to gain momentum. According to a January 2013 U.S. Department of Health & Human Services (HHS) news release,1 106 new Medicare ACOs were recently formed, ensuring access to quality care for as many as 4 million Medicare beneficiaries; since the passage of the ACA, 250 ACOs have been established, about half being physician-led.

The Center for Innovation, which receives $10 billion in annual funding, has its own set of programs carried out jointly with private payers. With programs like the Bundled Payments for Care Improvement Initiative (BPCI), the Comprehensive Primary Care Initiative (CPCI), and the Medicaid Incentives Program for the Prevention of Chronic Diseases (MIPCD), CMS’s primary purpose is to test innovative payment and service delivery models to reduce Medicare and Medicaid program expenditures. CMS expects that these programs will eventually yield results that shed light on new and innovative ways to improve health care and reduce healthcare costs.
The Commercial Market

While Medicare ACOs and other CMS initiatives are government-managed and -funded, private payers are watching closely and developing their own innovative programs. For example, for several years now, private payers have been providing financial incentives to primary care practices that establish patient-centered medical homes (PCMHs) pursuant to guidelines established by the National Committee for Quality Assurance (NCQA).

Insurers like United Healthcare, CIGNA, and Aetna also continue to develop their own non-Medicare “brand” of ACO. In these arrangements, providers work collaboratively with private payers to improve quality and reduce the cost of care, using evidence-based results to monitor the success of various performance-based payment programs. Similar to the Medicare ACO Shared Savings Program, commercial ACOs may share savings and/or provide other financial incentives to their ACO providers. A recent report that appeared in the American Medical Association’s (AMA’s) American Medical News,2 stated that there are currently an estimated 8–14 million commercially insured patients nationwide in non-Medicare ACOs, and this is a growing trend.

Private payers are slowly transitioning from fee-for-service/encounter-based reimbursement models to those that reward based on quality of care, clinical outcomes, and achieving verifiable cost savings. Bundled payments for acute and post-acute care, global payments, value-based payments, and pay-for-performance incentives are the new payment models that private payers are exploring and continue to roll out. Models such as these require physicians to share clinical data with payers in the hope that this information will offer providers and payers evidence-based guidelines for best practices in clinical care and protocols.

Integrated Teams

As both government and private insurers move from a fee-for-service model to one that rewards coordination of care for a defined population, the need for physicians, hospitals, and other ancillary service providers to clinically integrate has become apparent. Just as providers are being asked to share clinical data and best practices with payers, providers need to share the same information with their clinical peers—hospitals, integrated delivery systems, ancillary service providers, and other physicians. Medical practices that expect to participate in new payment and service delivery models with the hope of reaping the potential financial rewards must be willing to explore ways in which they can clinically integrate. This includes deciding on the degree of integration they wish to achieve. Clinical integration, which is still a new concept to many practices and even some established delivery systems, can be accomplished in a number of ways.

When physicians sell their practice to a hospital, the practice becomes part of an already established, clinically integrated delivery system. A potentially unfavorable consequence for these physicians is that they now work for the hospital system, which means giving up a significant degree of autonomy. Forming a large multispecialty group practice through the merger or consolidation of several smaller medical practices into a single larger one is another way for practices to achieve clinical integration. In this scenario, physicians generally retain a greater degree of autonomy. By joining an independent practice association (IPA), a physician hospital organization (PHO), or an ACO, a medical practice can also realize a certain degree of clinical integration, but generally to a lesser extent.

New Roles in Accountable Care

Physicians have been stretched to the limit. They are under pressure to see more patients to compensate for reductions in reimbursements and increased practice costs; now they are being asked to participate in and accept a greater degree of financial responsibility for the quality and service of care they provide to their patients. They are being asked to participate in programs created by both private and government payers that focus on preventive care and disease management, especially for chronic conditions and complex illnesses. Many physicians recognize that they can no longer do it all on their own and are turning to case managers, RNs, and physician assistants (PAs) to provide clinical support.

Practices are hiring case managers and RNs to help manage the care of patients with chronic conditions. They are employing a greater number of PAs, creating more of a physician-PA team approach to patient care. In fact, according to the National Commission on Certification of Physician Assistants (NCCPA),3 the number of certified PAs has increased from 40,469 in 2000 to 86,500 by mid-2012, and demand continues to increase. By employing case managers, RNs, and/or PAs, physicians are able to spend more time with patients who have critical or complex conditions, which is one of the primary initiatives under healthcare reform; furthermore, practices are usually able to see more patients, workflow typically improves, and PAs can bill for their services.

Practices that participate in certain initiatives,
such as the joint CMS-private payer CPCI, also are entitled to receive additional financial support in terms of enhanced reimbursements and “bonus payments” for doctors who better coordinate care for their patients. While this should certainly not be the overriding factor in deciding whether or not to participate in new payer initiatives, these additional revenue streams do help defray the additional costs associated with participation.

**The Financial Risks**

If medical groups are going to succeed in the new world of accountable care, they must be willing to take on additional responsibilities and bear a greater share of the financial risks associated with the medical services they provide. In a pay-for-performance model, for example, a practice may be willing to accept a reduced fee-for-service payment schedule with the understanding that physicians stand to earn more if they meet or exceed established quality care standards and/or achieve targeted cost savings. If they do not, they risk earning less.

Practices are also at greater financial risks when they make the investments necessary to participate in new performance-based payer initiatives. They will have to invest in new technologies such as EMR and more robust reporting software. They may have to engage consultants to help them meet new clinical guidelines, such as attaining the NCQA patient-centered medical home accreditation. They will most likely have to increase staffing for both clinical (mid-level providers, RNs, and case managers) and administrative positions.

**Staying Lean and Mean**

Practices have had to deal with decreasing reimbursements and increasing administrative costs for years now. Many have had to increase staffing to implement EMRs and other new technologies. Those practices that have been able to “get by” will most likely find it difficult to make the necessary financial investments that will be required of them. Those that are financially sound and fiscally responsible will be best positioned to invest in their practices and manage the financial risks associated with participating in new performance-based payment and service models.

Practices will have to make sure that they collect every dollar they are owed, whether from private payers, government programs, or patients. This means having adequate systems in place and properly trained staff to keep on top of collections and accounts receivable. Practices will have to maintain strict budgets to control costs. Their financial reporting will have to be timely and accurate, especially if they wish to borrow additional funds from lenders to help pay for new investments in their practices.

**Compensation Formula**

With physician compensation typically being one of the largest expense line items for a medical practice, this is another critical area that may have to be addressed. Many practices are recognizing that their existing compensation models may no longer be financially viable or equitable among their physician groups. Practices are transitioning from straight salaries or collection-based compensation models to productivity-based models, such as those based on achieving certain levels of work RVUs. Those practices that are truly innovative are also incentivizing physicians by making compensation dependent on achieving defined goals such as overall patient satisfaction, patient outcomes and other quality metrics. Put simply, these models align the goals of medical practices with the goals being established by both private and government payers.

**New World of Accountable Care**

There is no longer any question that both private and government payers are transitioning from pure fee-for-service models to ones that reimburse based on meeting new quality measures and achieving verifiable cost savings. While some practices are simply testing the waters, others are jumping on the bandwagon, participating in private and/or government payer initiatives. Others have made the decision to join a hospital system, recognizing that they do not want to “go it alone.” Those practices that want to be players in the new world of health care, however, must be willing to make investments and accept additional financial risks.

**References**


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