SGR fix and ICD-10 delay mean trouble

ICD-10 hold not good news for practices already prepared

With the U.S. Congress deciding recently to delay scheduled cuts in physician payments under the sustainable growth rate (SGR) and at the same time delaying the implementation of ICD-10, providers face the challenge of planning for huge changes without knowing when they will come.

The Senate passed a bill providing a 12-month delay for the changes resulting from Medicare’s SGR payment formula. Without the delay, the SGR would have cut Medicare payments by 24%. Avoiding the SGR cuts has become an annual ritual in Congress, which usually waits until the last minute to delay the process. The recent action was the 17th patch for the SGR.

There had been high hopes that this year Congress would finally fix the SGR so that it didn’t threaten physician payments every year and require constant patches. But after debate, Congress merely upheld the status quo and kicked the can down the road again. The move was roundly criticized by many healthcare provider organizations, including the AMA, the American College of Physicians, Surgeons, and the Alliance of Specialty Medicine. (See the story on p. 2 for the AMA’s response.)

Failing to kill the SGR was only part of Congress’ dubious achievements, however. The same bill that patched the payment formula also delayed the implementation of ICD-10 codes for a full year. Now the switch to ICD-10 will happen no earlier than October 1, 2015, instead of October 1 of this year. (See the story on p. 3 for more on the ambiguity of the new date.)

SGR patch hampers planning

Congress’ action was “extremely disappointing,” says Ted Okon, executive director of the Community Oncology Alliance (COA), a nonprofit based in Washington, D.C., that advocates for oncology practices and their patients. Given that both the House and Senate had agreed to eliminate the SGR and payment reform, hopes were high that physicians would finally be rid of the sword of Damocles hanging over their heads.

“This looked like our best chance, and I don’t think this outcome is very encouraging,” Okon says. “It
AMA says ‘Thanks for nothing’ on SGR patch

The AMA is “deeply disappointed” by the Senate’s decision to enact a 17th patch to fix the flawed sustainable growth rate (SGR) formula instead of coming up with a permanent solution to the issue.

“Congress has spent more taxpayer money on temporary patches than it would cost to solve the problem for good,” AMA President Ardis Dee Hoven, MD, said in a statement released after the patch. “This bill perpetuates an environment of uncertainty for physicians, making it harder for them to implement new innovative systems to better coordinate care and improve quality of care for patients.”

Hoven went on to say that “remarkable progress” was made this past year in reaching a bipartisan, bicameral agreement on policy to repeal the SGR, making the end result particularly frustrating. Going forward, the AMA will continue to encourage Congress to work toward permanent Medicare physician payment reform.

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“It’s an impediment to strategic planning,” he says. “This has actually forced some physicians to give up. That’s why you see more physicians selling their practices to a hospital and going to work for the hospital full-time.”

ICD-10 delay not good for everyone

The ICD-10 delay, meanwhile, could be seen as good news for some providers, but it will complicate matters for others, says Jordan Battani, a principal researcher with CSC, a consulting company based in Falls Church, Va., and managing director of CSC’s Global Institute for Emerging Healthcare Practices. Smaller practices and

leads you to question whether they can do it the next time around either. I’m generally not very optimistic right now.”

SGR patches have wider effects than just forcing physicians to face the threat of pay cuts every year, Okon explains. Without a permanent fix to the SGR, physicians are limited in how far they strategize for the future.

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Deadline for ICD-10 switch unclear, risks complacency

Until Congress or CMS comes up with more definitive statements, physician practices are in limbo regarding when they will switch to ICD-10, says Jordan Battani, a principal researcher with CSC, a consulting company based in Falls Church, Va., and managing director of CSC's Global Institute for Emerging Healthcare Practices.

“The language in the bill is ambiguous. It states that the switch is not to be earlier than October 1, 2015, but does that mean it will happen in 2015?” she explains. “It’s not clear.”

Getting a firm date for ICD-10 implementation is crucial for practices to be able to plan and allocate resources, Battani says. She worries that if CMS cries wolf too many times by declaring a deadline and then backing off, some physician practices will not take any deadline seriously.

Then if the deadline actually comes to pass, those practices will be unprepared and potentially face income problems severe enough to shut them down.

The delay also is inconsistent with a key part of CMS’ advice for surviving the transition: Minimize the time you are using both ICD-9 and ICD-10, and the time you are “translating” the old codes to the new codes. Any practice—or payer—that was ready for the transition this year may find they have to continue with that overlap longer than they planned, Battani says.

“Unfortunately, even if they give us a new date for when the transition is really going to take place, providers may not believe them,” she says. “CMS told us definitively in the past year that there would be no more delays, and here we are.”

Switching to ICD-10 is a big project for any practice, involving technology and software changes, major process overhauls, and a big investment in staff training. If a practice is already far along in its transition process, the delay means having to sustain all of its momentum for another year, she explains.

“People have been in a very big push to make that deadline, and now it’s paused. For a big project like this it is hard to maintain focus, momentum, and organizational commitments, and to keep resources available for when you need them.”

—Jordan Battani

ACOs not the only future path; alternative strategies emerge

Physicians are hearing a lot of talk about accountable care organizations (ACO) as the wave of the future, with many being recruited to join and others trying to make themselves appealing with extensive metrics detailing their quality and efficiency. But what if an ACO is not right for you?

Well, you’re not alone. About 60% of physicians are not committing to an ACO, according to recent research in the journal Health Services Research. There are alternatives to ACOs that can be a better choice for some physician practices, says Monica Kaden, MBA, ASA, principal with Fischer Barr & Wissinger,
a leading accounting firm in New Jersey, and an expert in valuing medical practices. It is not necessarily in the best interest of a group of physicians to join a hospital or ACO, or to merge with another group, if they already have good contracts with insurance companies, operate efficiently, and are profitable, she says.

“We have a client, a large medical group, that is independent, highly efficient and profitable, and has excellent insurance contracts,” Kaden notes. “There is no incentive for them to join another large medical group.”

All physicians, whether independent or in a group, must keep up with the demands of regulation, such as having electronic health records and meeting HIPAA requirements, Kaden says. The onus is on the physicians to make sure they are keeping up with these requirements, but if they can, she says there is no urgency to merge with others.

Many specialists, especially in New Jersey, have maintained their independence, Kaden notes—by purchasing the necessary electronic health records and making the conversion themselves.

Compliance always a concern

Many practices have a staff member who is knowledgeable about the privacy laws, HIPAA requirements, and other concerns and can ensure the practice is compliant. Having this kind of resource can make it easier for a practice to avoid ACOs or other collaborations, Kaden says.

“As long as the practice has someone or a few people whose job it is to remain current with the regulatory demands, a practice can remain independent,” she says. “Many physicians would prefer to remain independent and in charge of their practices as compared to being employed.”

Kaden notes that joining an ACO can be the right decision for some practices, but she cautions that the cost savings under this model are still being tested.

“The jury is still out whether the ACO model will remain in the future,” she says. “Though the healthcare industry is changing permanently in many respects, we are still far from socialized medicine. Many physicians still have the opportunity to remain independent and viable, though it requires increased effort and investment on the part of the physicians.”

Doctors expanding services

Some physicians are changing their practices to specialty care that seems to offer a more promising revenue stream, says Bill Bithoney, MD, a board-certified pediatrician and a managing director at BDO Consulting, the fifth largest accountancy network in the world. Bithoney formerly served as CEO, CCO, and CMO at Sisters of Providence Health System in Springfield, Mass., where he developed a model ACO. Many of these physicians are specializing in weight loss programs.

“Though the healthcare industry is changing permanently in many respects, we are still far from socialized medicine.”
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“They’re looking for other ways to make money rather than relying on the typical care they have provided in the past. A lot of dermatologists are learning to give injections because that can be profitable even in the new healthcare arena,” Bithoney says. “It is similar to what happened 10 years ago when we saw physicians banding together to start physician-owned hospitals. They were looking for a way to stay profitable.”

Physicians also are banding together as independent physician associations (IPA), which improves their ability to practice independently but still nets them better insurer reimbursement rates, Bithoney notes. Partnering with a hospital can also up physicians’ negotiating position, he says. “Anything you can do to gather together as a group of physicians is going to be helpful. You will always have more negotiating power and more security than if you are on your own.” (See p. 5 for more on group options.)

Micro practices emerging now

Concierge practice groups can be attractive, Bithoney says, particularly because physicians can remain profitable while providing more personal care to fewer patients. A practice that has only 600 patients and charges them $1,000 a year for concierge medicine is already earning $600,000 per year and can still charge for reimbursement, he notes. Not a bad deal.

A newer concept is the “micro practice.” There are only about 100 operating in the country so far, Bithoney
says. The premise is that the practice dramatically cuts its overhead costs by caring for a smaller number of patients and booking fewer appointments each day, he explains. Typically the micro practice is a single physician working with an assistant—and no one else.

“It’s a practice with essentially no overhead,” Bithoney says. “Instead of seeing 50 patients a day, they see maybe 12 or 15. They’re still able to bill insurance, but by eliminating all the overhead physicians can do fairly well with this model.”

A micro practice requires good software to make streamlined staffing possible, so that cost has to be factored in, he says. The practice must be highly efficient to work. As part of concierge care within the micro practice model, some physicians are also negotiating with insurers to pay for Skype and FaceTime visits, Bithoney notes.

Choose what’s right for you

What path to choose? It often comes down to personal preferences and priorities, Bithoney says, adding that the lifestyle questions are as important as the hard numbers. An ACO or hospital employment may relieve some leadership pressure, for instance, but concierge service will mean being on call 24 hours a day and not having your patients covered by another doctor.

“I think the doctors who have remained in private practice have an independent streak,” he says. “That can still work for you if you are tremendously efficient and choose your practice style carefully. But for so many physicians, there is an appeal to joining forces with others.”

IPAs are becoming more attractive to some physicians who don’t want to go it alone but are concerned about the costs required to join an ACO, says Andre L. Lee, DPA, FACHE, an adjunct faculty member at Kaplan University School of Health Sciences and a healthcare administrator with more than 35 years of experience, having served as CEO of three hospitals and owned five hospices. ACOs may not admit physicians who do not meet their standards for electronic health records and other technology, he notes, and physicians are skeptical about recouping their investment.

“An IPA or a similar group offers them the economy of scale without completely taking over how they practice medicine. They are still independent physicians in a sense, but they get some benefits from being with the group,” Lee says.

He cautions that physicians sometimes drag out the decision-making process for too long because they are uncertain about the investments required for an ACO or the potential savings from it or other alternatives. In particular, he says, doctors can be too hesitant about committing to an electronic health record or other software system because they are afraid it will be outdated by the time they get it. It most likely will be, he says, but that is the nature of all software investments.

“Physicians are facing a challenge with these decisions, but you have to choose something,” Lee says. “You can’t go on like the same as you did five or 10 years ago, so it’s up to you to choose a model that works for you.”

National companies, private equity are options

When a hospital alignment does not seem to be the right choice, physician groups have their pick of several national companies to join as a smaller practice while reaping the benefits of a large organization, says Fred Davis, MD, founder of the physician practice management company ProCare Systems.

“There are some national companies that have practices in several states and allow those groups to have some sense of autonomy, but there is also corporate control,” says Davis.

“The centers are individually owned but part of a larger group. They have to operate according to structured rules and regulations, and you are bound by contractual arrangements.”

The ability to achieve a balance of centralized corporate and local decision-making will separate the losers and winners among these corporate entities, he predicts, noting that private equity also is breaking into the medical practice market. Many private equity deals are meant to occur for a certain number of years before a sale or going public. When that next iteration happens, there is a payout for physicians.

“The physicians give up a portion of control of their practices for the promise of a payout in the future,” Davis says. “They have to subjugate their individual needs to the needs of a bigger company, and understand that the stronger and more successful the company is, the more individual value will be created for them in the long term.”
Unclear how ACOs will split the cost savings

The big selling point for accountable care organizations (ACO) is that they will improve quality of care while also lowering costs, and the physicians can share in those savings. But just how much physicians will get is not clear yet.

Analysts from Johns Hopkins University in Baltimore suggest that the most successful of the first 360 ACOs not participating in Medicare’s shared savings program will receive a bonus of $5.2 million each, according to an article in the Journal of the American Medical Association. Sharing that with member physicians means each individual participant will collect several thousand dollars, they say.

How the money is split will affect the success of the ACO movement, the authors suggest. Shared savings should be distributed according to dimensions that recognize performance, equality, “systematic disadvantages,” luck, and team contributions, they say.

“Distributional fairness is intrinsically important as an ethical matter,” the authors write. “It is also instrumentally important; for example, if shared savings plans treat participating clinicians unfairly, those clinicians may be less likely to invest fully in the ACO’s mission, undermining the likelihood of success.”

Even if the division is fair, physicians shouldn’t expect payment any time soon. The distribution question won’t be germane until the ACOs actually show savings, and that may be a while, says Laura Beerman, director of customer segment analysis at Decision Resources Group, a consulting company in Burlington, Mass. “Earning any meaningful amount of money in the first few years is unlikely, and even then it will be offset by the investment required by the member physicians,” she explains.

Beerman’s company, which monitors ACO activity, has data showing that 70% is a typical percentage of shared savings allocated for physicians. Primary care physicians receive the largest share, as much as 90% in some outlier cases. A 60% share for primary care is closer to the median, she says.

“There also is a portion of the shared savings that is usually put back into supporting or expanding the infrastructure of the ACO,” Beerman explains. “We have seen some cases in which the ACO says that for the first year or two years, any and all of the shared savings will be put back into the infrastructure.”

How much of a reward will make physicians feel their investment in technology and other ACO requirements was worthwhile? Beerman says that question is still open, but she encourages a healthy skepticism in doctors.

Beerman understands physicians wondering if ACOs are just a dressed up version of HMOs, PPOs, and capitation. A few years from now the effort may not even be called accountable care, she says, depending on how successful ACOs are. But the overall concept will stay, she says. “Two years from now we may talking about ACOs or about value-based reimbursement in general, but that train is leaving the station,” she says. “There are so many commercial ACOs now, and you see a lot of payers dedicated to risk-based models with their physicians. Physicians are right to be skeptical, but be adaptable as well because value-based reimbursement is here.”

ACO model met with skepticism by some

Many physicians are jaded about the periodic revolutions in healthcare, such as the moves toward PPOs and HMOs and their promised great strides in efficiency and quality, notes David Rosen, MD, a board-certified anesthesiologist and founder of Midwest Anesthesia Partners in Chicago. Those experiences are making some physicians hesitant to join accountable care organizations (ACO) even though there is considerable pressure to do so, he says.

“Perhaps this model will collapse under its own weight, but it will take many years and many thousands of physicians signing on before that would occur,”

Reference
Rosen says. “The fear and uncertainty created by the ACO move has a lot of doctors just throwing up their arms and saying they don’t know what to do.”

Trying to carry on with business as usual is one option, but not a very realistic one, Rosen says. The changes brought by healthcare reform are going to affect physician practices so drastically that yesterday’s strategies are unlikely to be effective in the coming years, he says.

Physicians are seeing a drop in patient volume, Rosen says—his practice saw about a 5% drop in all of its sites in the first quarter of 2014. He attributes the drop to changes in insurance policies that resulted in lost coverage or higher deductibles. Physicians also are leaving the field.

“It’s created a sort of hiring freeze for most providers,” Rosen says. “Older physicians also are retiring earlier, when they might have planned to work years more. From the EMRs that were forced down their throats to now the ACO move, a lot of physicians are just saying they quit. Usually with that attrition you would expect a lot of hiring to compensate, but we’re not seeing that because people are so worried about the future.”

**CMS to increase Medicare Advantage by 0.4%**

Lobbying by the insurance industry resulted in CMS announcing recently that it will increase the overall rate for Medicare Advantage plans by 0.4% in 2015. This came as a surprise because CMS had previously announced in February that the rate would be cut by 1.9%.

CMS Principal Deputy Administrator Jonathan Blum said in a phone call with reporters that the reversal was prompted by policy changes and new estimates of Medicare Advantage costs. Those policy changes included backing off from an earlier proposal to require that home risk assessments be confirmed by in-office assessments.

Before the Affordable Care Act, Medicare Advantage plans were paid over 10% more compared to traditional Medicare, costing the program more than $1,000 per person each year, while quality and health outcomes were similar to those enrolled in traditional Medicare. The changes underway revise payments to Medicare Advantage plans to be more consistent with costs in traditional Medicare, while incentivizing quality improvements by basing part of Medicare Advantage payment on plan quality performance, Blum explained.

The rate announcement was accompanied by other non–Affordable Care Act changes to increase payment accuracy, such as updating the methodology to calculate risk adjustment normalization factors. Payments will vary by plan based on the plan’s location and star rating. Overall last year, plans instituted modest premium changes and overall enrollment grew by more than 5%.

**Number of advanced practice clinicians growing, with more incentive pay**

Advanced practice clinicians (APC) are in high demand, and many employers are offering incentive pay, according to the 2013 Advanced Practice Clinician Compensation and Pay Practices Survey Report.

The report details survey research conducted by the American Medical Group Association, a trade association representing medical groups and integrated health systems, and Sullivan, Cotter and Associates, a healthcare compensation and human resources management consulting firm. The survey revealed that approximately two-thirds of organizations reported an increase in their APC workforce within the past 12 months, and two-thirds project an increase within the next 12 months.
With the continued growth of the APC profession, there has also been an increase in the number of organizations that have APCs serving in administrative roles. This year, 31% of responding organizations indicated that some of their APCs serve in administrative roles, which is an increase from 20% in 2012. In addition, 14% of responding organizations indicated that APCs report to a director of APCs in 2013, compared to 1% in 2012. “This increase may signal a move toward integrating APCs across systems and developing a more comprehensive strategy for managing this important provider group,” says Kay Jensen, principal and employee compensation practice leader for SullivanCotter.

Total cash compensation varied by broad specialty area, ranging from nurse practitioners and physician assistants in medical specialties earning a median of $97,858 and $97,272, respectively, to a median of $104,000 earned by both nurse practitioners and physician assistants in hospital-based specialties. While base or guaranteed salary continues to be the primary component of cash compensation for APCs, 45% of respondents use a combination of base or guaranteed salary and incentive pay for at least some of their APCs. In particular, the top measures used by participants for nurse practitioners and physician assistants are work RVUs and quality. When these incentives are provided, they contribute a median of approximately 10% of all compensation plan components.

Medicare data release not welcomed by some physicians

HHS’ recent release of physicians’ Medicare claims data, including billed charges and total payments, was met with consternation by many physicians and their professional groups, who say the information is misleading and confusing to the general public. Before the data release, consumers had limited information about how physicians and other healthcare professionals practice medicine, HHS Secretary Kathleen Sebelius said upon the release’s announcement. “This data will help fill that gap by offering insight into the Medicare portion of a physician’s practice,” she said. “The data released today afford researchers, policymakers, and the public a new window into health care spending and physician practice patterns.”

The new data set has information for over 880,000 distinct healthcare providers who collectively received $77 billion in Medicare payments in 2012, under the Medicare Part B FFS program. With this data, Sebelius said, it is possible to conduct a wide range of analyses that compare 6,000 types of services and procedures, as well as payments received by individual providers. The information also allows comparisons by physicians, specialties, locations, types of medical services and procedures delivered, Medicare payments, and submitted charges. The data set is available online at http://tinyurl.com/hhsrelease.

The move was not welcomed by many physicians, and AMA President Ardis Dee Hoven, MD, said the HHS data release is misleading to most people. “We believe that the broad data dump today by CMS has significant shortcomings regarding the accuracy and value of the medical services rendered by physicians,” Hoven said. “Releasing the data without context will likely lead to inaccuracies, misinterpretations, false conclusions, and other unintended consequences.”

Thoughtful observers concluded long ago that payments or costs are not the only metric to evaluate medical care, Hoven said. Quality, value, and outcomes are critical yardsticks for patients, and the information released by CMS will not allow patients or payers to draw meaningful conclusions about their care’s value or quality, she argued. “The AMA is disappointed that CMS did not include reasonable safeguards that would help the public understand the limitations of this data,” Hoven said.