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Health Care Reform's Changes and Challenges: What Does This Mean for Physicians?

By Edward K. White

It is no secret that the federal government is back at the task of reforming the Medicare payment system. It is clear that the Medicare program cannot be sustained in its present form as the current growth rate in Medicare expenditures threatens to bankrupt the system in the next decade, or sooner. Adherents believe that the Patient Protection and Affordable Care Act will reduce costs and avert a looming crisis, but health care reform creates a lot of confusion and anxiety for providers and, in particular, for physicians.

Many physicians may believe that they are at a crossroads and can choose to either become hospital employees or remain independent and struggle to survive. Yet physicians do have another choice. Physicians can develop their own independent networks and participate in the opportunities that will come with the reforms.

This article takes a hard look at what health care reform will mean to physicians in the future and how physicians can position themselves to participate in the opportunities that will emerge. Perhaps the most important thing for physicians to realize is that they are critical to the success of any health care reform effort and that physician networks (whether created by hospitals, physicians or private investors) will be the key to transforming the health care system.

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Predicting exactly what might happen with health care reform is difficult, but the following are almost axiomatic points for the future:

1. The industry is not going to stay the same.
2. Consolidation must occur at multiple levels of the health care system to force efficiencies in the delivery of health care services.
3. Physician networks will be the key to managing down costs and transitioning reimbursement from fee-for-service to forms of capitated payments.
4. Whether physician networks are hospital created, physician created, or formed with the assistance of private investors, the most efficient networks will have the potential to provide the highest incomes to their physician members.

To understand where the health care industry is going with health care reform, it is worth spending a moment to understand how the reform effort has evolved.

The first major attempt to reform the federal health care system to control expenditures occurred in the 1990s with the Clinton administration's efforts to encourage managed care and the use of primary care gatekeepers to limit access to more specialized services. This attempt at health care reform was not based on legislative mandates, but was basically prompted by a series of public discussions of proposals to restructure the health care system. Nevertheless, the discussions sent the entire health care industry into a period of consolidation led by hospitals acquiring primary care medical practices. This effort largely failed as managed care systems never completely evolved due, in part, to the fact that state legislatures passed laws to limit the con-

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trols managed care companies would have over patient access to medical services.

After the failed efforts to reform the Medicare system in the 1990s, the industry began to wrestle with the concept of trying to align hospital and physician incentives to work toward the common goal of reducing health care costs. The most notable of these efforts was referred to as ''gainsharing'' programs. These programs were designed to compensate physicians with a portion of the cost savings they helped to generate in the hospital setting.

While the gainsharing programs held a lot of promise, the Office of Inspector General (''the OIG'') issued a pronouncement that these programs presented significant risks of violating the federal ''Civil Monetary Penalty'' statute (the ''CMP'' statute). The CMP statute is designed to prevent hospitals from incentivizing physicians to limit medically necessary services to Medicare beneficiaries. The OIG basically said that while the objective of gainsharing was meritorious, the agency did not have the legal authority to waive the provisions of the CMP statute and Congress would need to act to make changes to the law. As a result of the OIG's stance, the gainsharing program efforts largely disappeared.

In 2010 the Obama administration again started to reform the Medicare system. The key difference with this reform effort is that legislation was passed and with the legislation comes mandates and time frames for implementation. Rather than the managed care proposals of the 1990s, the focus today is on the clinical integration of health care providers (i.e., hospitals, physicians and ancillary service providers). In addition, the current reform effort is also focused on changing the reimbursement system with the goal of moving away from fee-for-service reimbursement, which is seen as encouraging utilization of services.

Clinical integration, in its simplest terms, is the creation of relationships among providers that require interaction and interdependence in their provision of medical services and are designed to enable them to jointly achieve cost savings and quality improvements. The key to clinical integration is aligning financial incentives among providers to encourage the joint pursuit of the cost-saving and quality-enhancement objectives.

One of the models in the 2010 Medicare reform legislation designed to achieve clinical integration is the ''accountable care organization'' (''ACO''). An ACO is an entity designed to facilitate collaboration among physicians and other providers to coordinate patient care with the objectives of decreasing costs and improving quality.

An ACO functions by contracting with providers and coordinating the development and implementation of processes designed to decrease costs and improve the quality of health care services. These processes will change the way health care services have traditionally been provided. No longer will a provider simply focus on a patient's care during an encounter in a physician's office or in the hospital setting; rather, a process for the patient's treatment over a period of time will be designed, based upon principles of evidence-based medicine, and the steps in that process will be tracked and reported as performance measures throughout the patient's care. These steps will be designed to generate lower costs and higher quality outcomes across patient populations.

The necessary capabilities of an ACO include: effective physician leadership, information technology systems to track and report care performance measures, physician and staff cultures that support performance measurements, and the ability to create the necessary contractual relationships with physician providers. Physicians are critical to the creation and sustainment of a successful ACO.

An ACO that successfully achieves cost savings and quality enhancement goals will receive additional payments from the Centers for Medicare & Medicaid Services (''CMS''), referred to as ''shared savings.'' These payments are the financial incentives designed to align providers in the clinical integration effort. An ACO's portion of shared savings represents a premium for providers in addition to a fee-for-service payment from the Medicare program. These premiums have the potential to shift provider relationships towards clinical integration to compete for these incremental revenues.

Over time, the shared savings will likely decline as providers make the major changes necessary to push inefficiencies out of the health care system. At this point, it is likely that Medicare reimbursement will begin to shift to one or more forms of capitated payments. Capitated payments are simply fixed payments (to be shared among providers) to cover all or a portion of a patient's health care services over a defined period of time.

In the short term, the capitated payments may appear as ''bundled payments'' or as payments for ''episodes of care.'' Currently, CMS is conducting pilot projects testing bundled payments and payments for episodes of care. A bundled payment is a fixed fee for a procedure that is shared by the providers participating in the procedure. A payment for an episode of care is a fixed fee for an acute care illness, which is defined by a certain number of patient care days, (e.g., a certain number of days pre-admission, the days of hospital admission and extending to a certain number of days post discharge from the hospital) that is shared by the providers providing patient care services during the episode of care.

Over time, capitated payments could evolve to the point that an ACO receives a fixed fee at the beginning of the year for each Medicare beneficiary assigned to the ACO and in return the contracted providers agree to provide all necessary services (both hospital and physician services) to those Medicare beneficiaries during the year. To the extent the services are provided at a total cost less than the capitated payment, the ACO providers will make a profit, and to the extent the services are provided at a cost above the payment, the ACO providers will lose money.

An important point to recognize in the evolution of reimbursement methods to capitated payments is that providers will begin to bear economic risk in connection with the provision of their services. The long-term efficacy of this type of model requires that providers are not only efficient in the delivery of high quality services, but that providers will have to begin to focus on helping to keep patient populations healthy, where possible, by educating and monitoring patient populations to avoid preventable illnesses. This will be particularly important if reimbursement successfully evolves to the point that a capitated payment is made each year to an ACO to cover the cost of each Medicare beneficiary's services over the course of the year.

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One of the most important points for physicians to understand about an ACO is that nowhere in the law or regulations is there any requirement as to how the payments from an ACO will be allocated among the participating providers. The allocation of the ACO revenues (whether it be shared savings or some portion of a capitated payment) will simply be a product of negotiations among the ACO and the providers. This means that the allocation of the incremental revenues for the Medicare beneficiaries will be dependent, to some degree, upon the negotiating leverage a provider can create with the ACO (whether it is by importance of the specialty or the sheer size of the provider organization).

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Another important point for health care providers to understand about an ACO is that Congress granted waivers of the CMP statute, and other regulatory requirements, to ACOs to allow shared savings to be paid directly to participating providers for helping to reduce costs in the hospital setting. Outside of a Medicare health plan, the ACO is currently the only mechanism to step outside of the application of the CMP statute and provide financial incentives directly to physicians to reduce Medicare health care costs in the hospital setting. In essence, ACOs can now accomplish on a large scale what gainsharing programs had hoped to do in the past. The significance of this feature of an ACO cannot be understated in the current regulatory environment. This feature alone could cause ACOs to proliferate and become a cornerstone of driving down Medicare health care costs.

As the movement toward clinical integration continues, an inescapable fact is that providers' costs will simultaneously increase. Information systems to track and report performance measures (the hardware, software and specialized personnel to operate the systems) will become a necessity as will the personnel needed to oversee the ''medical management'' processes. These clinical integration expenses and the expense of increasing regulatory compliance (e.g., specialized personnel for billing, compliance advice and costs associated with dealing with enforcement actions) combined with the downward pressure on reimbursements threatens the incomes that physicians and other providers can earn in the system.

This raises the question of what should physicians do in the future. One approach is for physicians to sell their practices to local hospitals and become hospital employees. With the passage of the 2010 health care reform legislation, hospital acquisitions of physician practices has accelerated. In addition to direct employment, hospitals have also created relationships where physicians may keep their practice assets independent and enter into contracts to provide professional services on behalf of the hospital while utilizing their own equipment, space and staff (this relationship is often referred to as a ''physician services agreement'' or ''PSA''). Under both of these models the hospital is billing for the physician's services and assuming the risk of changes in reimbursement. The particular approach taken by a hospital is normally driven by local market conditions and, in some instances, can be driven by a physician group's ability to negotiate with the hospital.

The hospital employment or PSA approach may be fine for many physicians, and, in fact, the majority of physicians will likely be hospital employees or in PSA agreements with hospitals in the future. However, in return for the hospitals absorbing the reimbursement risks associated with physician practices, physicians are leaving it up to the hospitals to determine what they will earn in the future. What is unknown is what hospitals will be able to afford and what hospitals will be willing to pay physicians once cost-saving efforts take hold because a large part of the savings will show up as reduced revenues in the hospitals. The most likely way for hospitals to make up the lost revenue is through higher volumes achieved through increasing the hospital's market share. If a hospital is unable to make up the lost revenue through increasing its market share, then the hospital's physician network may become a target from which to squeeze out costs as the hospital's revenues decline. Cost reductions could come in the form of reductions in the management and support personnel assigned to the hospital's physician network or a reduction in the compensation to the network physicians.

Simultaneously, shifting reimbursement away from fee-for-service payments presents a separate set of issues for hospital employed or PSA physicians. Most hospital contracts today with physicians are structured based on an RVU productivity compensation system that rewards sustained production under a fee-for-services reimbursement system, yet reimbursement is going to start shifting to payment methods that encourage and reward fewer services. It is not clear how hospitals will transition from RVU productivity-based compensation systems once reimbursement methods make changes in those compensation systems a necessity.

Physician Networks.

For those physicians who are not going to be hospital employees (whether because they are too independent minded, they are not invited to become members of a hospital network, or because they became members of a hospital network and decided to leave) then doing nothing as health care reform proceeds will likely mean a reduction in their personal incomes as downward pressures on reimbursement continue, large physician networks (whether hospital, physician or investor owned) negotiate their allocations of the shared savings and capitated payments, and the technology and other costs associated with providing health care services continue to increase.

For those physicians not joining hospital networks, they do have another choice as they can begin to consolidate their practices and create independent physician networks. There are many benefits to consolidating physician practices including: jointly contracting in larger numbers for revenues; achieving efficiencies with operating costs (sharing costs and achieving economies of scale for costs related to technology systems, payroll systems, retirement plans; malpractice insurance, other employee benefits and compliance and legal services); in addition to providing a vehicle to transition their practices upon retirement.

There are at least three ways physicians can consolidate their practices to create their own networks. First,

multiple groups can completely merge all of their business operations into a common group (a ''complete merger''). A complete merger works well when the groups have similar values (i.e., work ethic, profitability, management cultures, etc.). A perfect alignment of values is not always going to be present, and there are models that can accommodate those groups that want to achieve the benefits of consolidation but do not want to completely combine their business operations.

For those groups that are less willing to completely combine their businesses, there are two formats that allow groups to consolidate their practices yet maintain a certain level of autonomy with their historic practices. Both of these formats make it easier for a group to exit the arrangement if things do not work out as planned and can also be used to isolate and allocate the profits of each historic group back to those physicians in the historic group and avoid the historic groups from having to subsidize one another in the consolidated entity.

One format is sometimes referred to as a ''divisional merger'' (but is referred to here as a ''cost center model''). In this format the groups merge their businesses, but each historic group maintains the principal decision-making authority over the operations at its practice site and operates as a separate cost center within the consolidated organization. While a portion of common overhead expenses are shared across all of the groups to create efficiencies through economies of scale (e.g., lower costs per physician for payroll processing, billing and collection services, information technology systems, etc.), physician revenues and site specific expenses are allocated back to the historic practice sites and the profits at each site become the incomes of the physicians practicing at that site.

The second approach is to have groups remain even more independent (separate employees, equipment and office space – just like the hospital PSA arrangement), and each group contracts with a new physician organization (sometimes referred to as a management services organization or ''MSO'') to which the group provides the physician services, office space and equipment on behalf of the MSO and the MSO bills and collects for the services. Under both of these models protections can be built into the consolidated organization to keep one practice site from having to subsidize another.

Under all three of these consolidation models, (the complete merger, the cost center model and the MSO model), the physicians are all billing under a single provider number in the name of the consolidated group. The advantage of all three of these models is that the physicians are creating their own physician network that is jointly contracting for revenues and expenses and can deliver enhancements on both points. Negotiating in larger numbers can bring enhancements with private payors as well as with an ACO where the physicians are negotiating for an allocation of shared savings or a capitated payment. On the expense side, not only does negotiating in larger numbers help generate volume discounts, but the groups can also share and access services, through economies of scale, that might not have been affordable alone. These expenses include information technology systems and support services and the compliance and legal services that will be necessary for physicians to effectively deliver health care services in the future. The objective of all of these models is to improve the bottom line and the physician incomes.

With each of these three consolidation models there are regulatory issues that have to be managed that include issues with the sharing of revenues from diagnostic services, retirement plans, other employee benefits, antitrust issues, etc. But there are techniques and strategies that can be used to build sustainable models to satisfy a physician's objective of enhancing revenues and becoming more efficient with the expenses of their business.

Conclusion.

Over time, physician networks are going to be the key to any effective and lasting reform of the Medicare system. That is one reason why hospitals are so aggressively pursuing the creation of their own networks. An independent physician network that maintains the appropriate information systems and processes to effectively participate in clinical integration efforts will create value beyond the incomes it delivers to its participating physicians. A well-managed consolidated physician network creates the possibility that the ownership interests in the organization will have independent value that can be realized upon transfer of the interests as physicians enter and exit the organization (e.g. upon retirement or otherwise), creates the possibility that other networks will seek to combine with the organization to achieve further economies of scale, that the network could ultimately be bought by a strategic buyer, or become a joint venture partner with another investor to create its own ACO to pursue the incremental revenues in the Medicare system.

To date the majority of the ACOs that have already been formed and approved for operation by CMS, are physician organized ACOs or joint ventures between a physician network and another investor without a hospital or hospital network directly involved. Some of these joint ventures involve a private payor putting in all of the capital and management expertise to create the ACO in return for a split of the profits from the shared savings. A well-managed physician network will find similar opportunities in the future.

While it may be unfamiliar territory to many physicians to consolidate their practices into a larger business, other professionals (such as accountants, attorneys and engineers) have been successfully consolidating their professional practices into large organizations for years. Consolidation requires new skills, but there are resources available to help physicians with the financial, management and legal needs that consolidation will require.

The best advice for physicians now is to decide where you want to be in the future as health care reform continues to unfold and start working toward that objective now.

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