PRACTICE MANAGEMENT ADVISOR

Summer 2011

Making the business case for EHR implementation

CLINICAL COMANAGEMENT
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Making the business case for EHR implementation

Most of the literature that promotes the installation of an electronic health records (EHR) system emphasizes the clinical benefits it will produce. Yet there appear to be plenty of valid *business* reasons for investing in such a system. Let's take a look at some of the details.

Focusing on usage

Naturally, practices need to understand how much money it will require to install, implement and maintain an EHR system. But they should also be able to estimate the cost savings or revenue increases offered by the system. (See "The non-clinical benefits of EHR" on page 3.) In addition, after factoring in cost of capital, practices must forecast their return on investment as well as how quickly they'll get that return.

Unfortunately, quantifying the cost savings and revenue increases — both as an average for all practices and for a single practice — isn't easy. The few studies that have been done offer varying types of EHR-related data.

For example, the National Ambulatory Medical Care Survey focused on usage. It found that, in 2008, 42% of office-based physicians used full or partial ambulatory EHR systems in their practices. Some 13% to 17% used a basic system, which offered patient demographic information, clinical notes, prescription orders, patient problem lists, lab tests and imaging results.

The EHR systems of just 4% of those physicians surveyed were more advanced, offering electronic transmittal of prescription and test orders, warnings of drug interactions or contraindications, and guideline reminders at point-of-care. (These advanced features are part of the Stage 1 meaningful use criteria for incentive payments.)

Looking at experiences

In 2010, *Physicians Practice* magazine conducted a survey of 597 practices regarding their experiences with EHR system installation. Some 40% of the respondents said they have a fully implemented system, and another 8% use an EHR system selected and provided by a hospital. Of those with a system, 64% expect to see a return on investment.

In addition, after implementing an EHR system, 59% of the practices were able to reduce staff, another 21% moved staff to new positions and 71% said the system had improved their practices' work flow efficiency. On the other hand, 80% of the practices said they were confused by and didn't understand the federal rules on eligibility for EHR incentive payments.

A shortcoming of the *Physicians Practice* survey is that there's no attempt to ascertain the functionality level of each practice's EHR system and correlate that with results they achieved. Furthermore, no actual dollar figures were assigned to the improvements realized.

Counting the costs

The March 2011 issue of *Health Affairs,* a journal of health policy thought and research, reported on

the costs associated with implementing a single EHR system in a 450-physician fee-for-service (FFS) ambulatory care network operating through 100 health centers.

Each practice (composed of several physicians) spent $25,000 on initial infrastructure, such as switches, cables and Internet connections. An additional $7,000 went toward personal computers, printers and scanners for each physician. Annual maintenance costs, including software licensing, hosting and technical support, were just over $17,000 per physician.

An additional $36,000 per practice covered implementation tasks such as content development and customization, workflow redesign, training, and technical deployment. Each physician spent more than $10,000 on implementation, primarily entering data from paper records. The total average first-year costs per physician were $46,660 — remarkably close to the $44,000 in incentive payments available from CMS.

Once more robust data are collected on the value of the benefits accruing from an average EHR system installation, it will be easier to calculate either the payback period or the rate of return on investment.

The nonclinical benefits of EHR

If your practice still hasn't embraced an electronic health records (EHR) system, bear in mind that there are many potential *nonclinical* benefits to implementing one. In particular, you may enjoy cost savings or revenue enhancement from:

- Doing away with paper chart production, storage and maintenance,
- Minimizing data entry and handling,
- Eliminating the pulling and filing of charts, which leads to improved efficiency, decreased access time and fewer lost charts,
- Improving clinical care,
- Diminishing patient history/analysis time,
- Making fewer medication errors,
- Improving decision support,
- Optimizing clinical response time,
- Adhering more closely to clinical protocols,
- Enabling better disease management,
- Automating charge capture,
- Improving E&M coding,
- Increasing claims submission accuracy,
- Improving claims *re*submission, and
- Minimizing undercoding and lost charges.

Brightening your image

As your practice debates the pros and cons of installing an EHR system, keep in mind that image counts as well. Many patients view physician practices as being more sophisticated and up-to-date if they have implemented EHR technology.

So, despite the cost, perhaps you should look at it as a true "win-win" situation. Your practice gets the latest technology *and* the accolades of your patients.

Understanding both sides

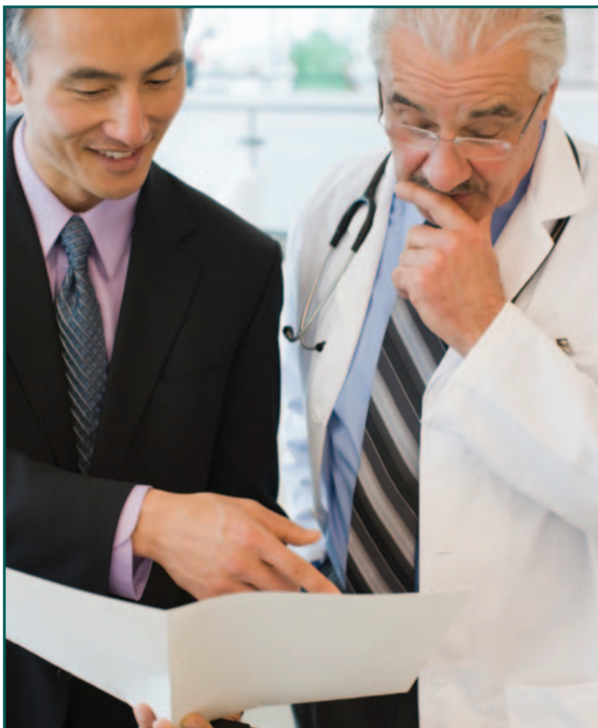
As you may have noticed, payors are pushing their providers to invest in EHR systems without offering much help or guidance. This is a challenge for all physicians when the operating standards for the systems aren't entirely clear, the reliability of the vendors selling them is sometimes cloudy, and the capital required is hard to come by. But physician practices should still understand both the medical benefits and the business justifications for making this move.

A relationship based on trust

Clinical comanagement, whereby a hospital buys or contracts for physician-led management services, is a significant step toward integrating operations — which is fundamental to health care system reforms. But you need to be mindful of the legal and practical factors involved.

Two models

Comanagement comes in two forms. In the first, a hospital contracts with a physician group or several groups to take responsibility for clinical and operational management of a hospital-related facility (such as a satellite primary care clinic) or service line (such as ophthalmology). In the second, a separate legal entity — owned by physicians or groups of physicians, or jointly by the physicians and the hospital — is created to provide some of the same services as does the hospital itself.



Typically, the parties create a compensation agreement that involves a base payment commensurate with the fair market value of the management services provided, plus an incentive fee tied to efficiency and quality objectives. Both parties should seek independent valuations by experienced appraisers to determine the fair market value of both compensation components.

Governance of the separate organization or the operations management is critical to the success of the arrangement.

Integration without employment

Comanagement may be attractive to physicians who want to integrate more closely with a hospital while maintaining their independent practices and not becoming employees of the hospital. It's clear that, with such a close-knit working relationship, the parties must trust each other completely.

The hospital must accept that it will surrender some control over its operations. The physicians, in turn, must understand that they'll take on substantial managerial and leadership responsibilities within the hospital.

In addition, governance of the separate organization or the operations management (whichever model is chosen) is critical to the success of the arrangement. If it's a true partnership of physicians and hospital, granting substantial authority to the doctors, their participation should equal or exceed the hospital's. This will likely present no problem with for-profit hospitals. Tax-exempt

hospitals, however, may insist on 50-50 equity arrangements and reserved powers to protect their charitable missions.

Legal matters

When a hospital and a group of independent physicians collaborate, a number of legal questions emerge. For example, the antikickback law may be violated if the comanagement agreement induces physicians to refer patients to the hospital. The Stark law requires that compensation in agreements between a hospital and physicians not be tied to the value or volume of referrals for "designated services." A comanagement arrangement can take advantage of several available Stark exceptions, however. Ask your CPA and a health care attorney for more information.

The Civil Monetary Penalty statute prohibits a hospital from making payments to physicians as inducement to reduce or limit services. So, comanagement deals should avoid incentive fees based on achieving cost reductions. Last, 501(c)(3) hospitals can't use a comanagement arrangement to confer private inurement, private benefit or excess benefits to the physicians.

Making it work

For comanagement to work, you should define the services to be performed under the arrangement, keeping in mind that those services are ones that the hospital otherwise would perform itself. Make sure you document the physicians' qualifications to perform the services and create a mechanism for ensuring those services are actually performed by the physicians.

Is your practice at risk?

How to identify areas susceptible to error or negligence

No physician practice purposely tries to lose money. Yet many practices are allowing revenue to fly out the window at alarming rates simply because their billing and coding processes aren't up to snuff. Put a stop to it now with a billing and coding audit.

Why audits are important

Internal billing and coding audits begin with an analysis of the services offered by your physicians and how often they've been performed in the last six months. The auditor wants to know whether your doctors are submitting accurate claims for reimbursement or over- or undercoding certain services.

In other words, are your docs using the appropriate CPT codes for all procedures? Are they following the guidelines and conventions required by payor payment policies? These questions and others like them are important to ask.

It's a team effort

To get the ball going, you'll need to bring together a team of individuals to oversee the process. The primary responsibility should go to a single staff member who has a good knowledge of CPT codes, the RBRVS, and payor reimbursement policies and practices. The rest of the team will consist of your health care consultant and other relevant staff and physicians.

Next, your audit team must decide whether the audit should be *pro*spective or *retro*spective, and how often the audits will be performed. A prospective audit looks at a sample of claims before they're submitted, while a retrospective audit reviews claims after they've been processed. In the latter case, any

billing errors or overpayments discovered must be resolved through the payor's repayment procedure.

The team must determine how large a sample of medical records will be taken and how they'll be selected. (The OIG recommends at least five records for each federal payor, or five to 10 medical records randomly chosen for each physician.) Make sure a true, representative sample is taken and that enough accounts are reviewed — pulling a small sample of records can yield misleading results. Then the team must select audit tools and criteria for determining the appropriateness of claims made for each medical record.

It's important to be able to confirm that services provided are "medically reasonable and necessary."

Dig for answers

The purpose of a billing and coding audit, as mentioned before, is to identify areas of heightened risk for error or negligence that warrant closer monitoring. To that end, the audit team must develop or obtain a checklist for analyzing the appropriateness of all aspects of each claim.

For example, does the claim show the correct physician and practice ID numbers? Should a different CPT code have been used to more accurately reflect the service delivered? Could a modifier have been added to the code to more accurately reflect the service delivered? And does the medical record substantiate the codes used?

It's also important to be able to confirm that the services provided were "medically reasonable and necessary." The determination should be made using the definition of that term from each payor's medical service agreement with the practice.

Next, the audit team must investigate whether language in patients' medical records matches and supports the services that were billed. To do this accurately, you must know which version of the CMS E/M coding guidelines the practice uses. The medical record must satisfy every required element of each service.

Make it right

Claims that weren't properly processed by the payor should be identified and the practice staff instructed how to correct the failure to pay as well as what they should do to prevent future problems. Be sure to document all of the work that went into preparing for and conducting the audit, and the remedial measures taken as a result.

If an audit uncovers a long-running pattern of errors, you may need to take more substantial remediation steps with payors. In such cases, consult your health care attorney.

It's your money, keep it!

If your practice is seeing profits trickle away, take action now. Your CPA is trained to review your billing and coding processes and find where revenue is draining away.

Practice NOTES

When it's time to sell, you'll know

According to a 2010 *American Medical News* survey, in 2009 hospitals owned 55% of all physician practices in the United States. That's up from 30% just five years before. This trend is being pushed by both physicians *and* hospitals. The question is: Should *you* sell your practice to a hospital?

Recognize the benefits

Many physicians are ready to give up ownership of their private practices because of limited reimbursements they receive from payors, reduced prospects for ancillary revenues, rising costs of practice operations and increased competition.

In addition, selling a practice to a hospital and accepting employment there can be quite attractive. For example, virtually all the stresses of practice management disappear, and you can count on predictable work hours and income streams.

Think twice

For all of the benefits, there are several reasons to hesitate before selling to a hospital. The hospital's philosophy about quality of care and profitability may be inconsistent with the practice's. Plus, the hospital may not be willing to commit sufficient marketing and improvement resources to the practice's growth.

In addition, the physicians may not feel comfortable with the hospital's performance-based compensation system. And the associated employment agreement will be for a term of just a few years: What will happen to the practice after that?

Look at the trends

When deciding whether to remain independent or sell the practice, look at nationwide health care system trends. Health care reform promises more patients with insurance coverage. Regional market developments will also play a key role. For example, commercial health insurers may dominate a market.

If continued independent practice isn't viable, selling to a better capitalized entity is usually the best alternative — whether it's a larger practice or a hospital.

Examine all factors

If a hospital expresses interest in your practice, you and your advisors should evaluate:

- The hospital's market share,
- The availability of referral sources from the hospital's medical staff,
- The hospital's management style and culture, and whether it's locally managed or part of a remotely managed system,
- The physician's role in governance, strategy and decision making, and
- The degree of continuing autonomy for incoming physicians.

Of course, you should also consider the convenience of the hospital's facilities to the practice's patient base, and the hospital's offer terms as well as its financial strength and access to capital.

Don't be hasty

Selling a long-established practice can be a painful career step. That's why it's essential to seek the counsel of both a health care attorney and your CPA. Together, they can structure legal options and prepare necessary financial projections so you can make the right decision.

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Think of us as your financial healthcare provider

Healthcare professionals often become so busy caring for patients that their own financial health suffers. That's because billings go uncollected, resources are poorly managed, staff members are inadequately trained, accounting systems are out of date, or other aspects of running a profitable healthcare business are not given the attention they require.

This is where **Gilmore, Jasion & Mahler, LTD** (GJM) comes in. Our experienced professionals excel in helping physicians and other healthcare providers enjoy maximum profit, minimum tax and robust financial health. In addition to our staff's high-level expertise in the area of healthcare financial management, our memberships in the Health Care Advisors Association and the Medical Group Management Association enhances our ability to offer comprehensive accounting, tax and business advisory services to our more than 600 clients in the healthcare industry.

Our firm is the exclusive local member of the National CPA Health Care Advisors Association (HCAA), a not-for-profit association of CPA firms dedicated to the delivery of superior quality services to the health care profession.

We offer all the experience and credentials you expect with a level of flexibility, commitment and service that will pleasantly surprise you. Our specialized services for healthcare providers include:

- Financial review and planning
- Staff recruitment and employee handbooks
- Industry statistics and benchmarking
- Accounting and tax services
- Business valuation services
- Compliance and health claims audits
- Practice management services
- Budgeting and cost analysis
- Computer hardware and software guidance
- Managed care plan review and analysis

We would welcome the opportunity to discuss your needs and answer any questions you may have about the topics covered in this newsletter, or about others relating to running a successful healthcare business. Please call us at 419-794-2000 and let us know how we can be of assistance.

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