

New payment models: Establish your baseline costs

Why is this step important?

The move from fee-for-service (FFS) to “value-based” payment models will require physicians to adopt more detailed accounting practices than they have typically used in the past. There are two reasons that this will become important.

First, many of these payment models require physicians to assume a level of risk with respect to the services they provide to their patients. Under these models, physicians can no longer assume that they will actually receive payment for each service they provide; to the contrary, they must assume that they will not be paid for services that are determined to be unnecessary or required only because of the physician group’s inefficiency or error. Moreover, and especially if the physician group has assumed risk for the services provided by others, they will also have to track the services that have been provided but have not yet been captured by their cash-based accounting systems because of delays between the provision of the services and the posting of the bills for those services.

Second, governmental, employer and other purchaser demands for cost-containment are likely to result in less payment for services regardless of the payment method. With smaller margins and greater risk, physicians will have to undertake a very serious, business-like review of the services they provide. Ultimately, this analysis will need to answer these key questions:

1. What does it cost you to deliver clinical service that you provide?
2. What does each payer pay for that service?

3. What is the difference between revenue and expense for each key service?
4. Can you close the gap on services that have a negative delta?
 - a. Can you provide the service more efficiently by reengineering the process; will your suppliers, landlord, staff, and other expense sources lower their costs to the practice; or will all of the gap be carried by physician cuts in salary?
5. Do you stop providing those services where you cannot close the gap between revenue and expense and the impact is detrimental to your practice?
6. Do you stop contracting with payers that are not willing to provide you the data you need to manage the risk they are demanding, or that are not willing to pay fairly for that risk?

In the commercial world, accounting practices are set up to easily answer these questions and these evaluations are routinely done. In health care, however, a detailed cost accounting approach is the exception rather than the rule. Typically, financial statements are done at the macro level of the enterprise (practice) or major service area. It is rare that there is a further breakdown like, “What does it cost to do an office visit for a new patient, return patient, patients with diabetes, etc.” *Conceptually, it is not difficult to setup such a system; it is just foreign to the industry.*

Generally, cost accounting requires allocating costs to the products and services sold. Some are allocated on a step-down basis using an established formula (like

administrative overhead) and others require direct allocation. This latter expense tracking usually is the challenge, as it requires tracking and capturing into the accounting system the supplies used, staffing resources and other expenses unique to that service. This tracking can be manually intensive if technology solutions are not employed. Allocating supply costs in turn requires sophisticated inventory controls and assignment of costs. The answers to questions like, "What cost do I assign for the vaccine just used?" if inventory costs varied over time and the precise cost for that vial is not known are not obvious. Assume, for example, that what is known is that in inventory there are 10 vials that cost \$150.00 each and 5 that cost \$125.00. Applying actual costs to a particular inventory item would require bar-coding or employing other cost tracking methods for each inventory item. Reasonable people would generally say that the cost of that precision outweighs the value of the obtained data accuracy. Thus, reasonable accounting compromises are expected.

So, how do you begin? This resource will discuss simple approaches that will give you basic insight into your costs that can be done quite quickly and progress to explore what it will take to establish a more sophisticated accounting practice. We will suggest questions to guide you on whether or not your practice needs anything more than a basic cost of service report. Finally, we will recommend approaches on what you can do to manage costs in your efforts to close the gaps you identify, including coming to terms with the reality that your practice may need to stop providing certain services it cannot practically do anymore.

Capturing Relative Value Unit (RVU) and cost data

Before agreeing to transition from FFS to a new payment system, physician practices must determine whether they will be able to stay in business if they are paid pursuant to the new methodology.

The first step to making this evaluation is determining the practice's underlying costs of doing business. While practice consultants use different methodologies to determine the cost of providing services, one of the easier methods is to use the Centers for Medicare & Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS) and its underlying Relative Value Units (RVUs).

Each Current Procedural Terminology (CPT®) code has associated with it a total RVU (tRVU) which can be adjusted based on any modifiers used. RVUs are created and updated by the Specialty Society Relative Value

Scale Update Committee (RUC) which meets three times a year to set new values, determine the RVUs for each new code, and revalue all existing codes at least once every five years. RVUs measure the relative level of time, skill, training and intensity to provide a given service. Total RVUs are a combination of physician work RVUs + malpractice expense RVUs + practice expense RVUs and are intended to reflect the relative costs of providing care, including geographical variances in costs. Most payer fee schedules are created by multiplying the total RVU by a conversion factor to create a fee schedule amount. More than one conversion factor may be used to address differences in ranges of CPT codes.

At the most basic level, calculating revenue per tRVU by payer is done by capturing tRVUs for all of your services billed to a payer and their associated payments. Simply divide the total revenue by the tRVUs and you now have your number. This is also the equivalent of a conversion factor you can use to compare how close you come to the conversion factor in your contract with that payer. It will never be the same as the real world one you calculated, however, as bad debt costs, denials and other factors will always create a gap between your internal conversion factor (revenue per tRVU) and the one contractually agreed to.

Calculating costs per tRVU can be done in a similar fashion. For a blunt analysis, simply add up your total practice costs (physician and non-physician salaries and benefits, rent, professional and other insurance costs, supplies, etc.) for the period for which you captured the tRVUs, and divide the total costs by the total tRVUs. A simple comparison of costs per tRVU to the revenue per tRVU will quickly let you know if there is an issue with one or more of your payers.

This is the absolute minimum analysis that you must do before you embark on any payment system that involves risk. There is no magic in risk-based payment systems. If you agree to a contract that does not cover the costs of the services you must provide plus the additional overhead associated with risk-based contracting (actuarial assistance, stop-loss insurance, accrual accounting, etc.) you will lose money under that contract.

Deeper dive: The need for accurate and comprehensive analysis

While the very basic financial assessment described above is an absolute necessity for any physician practice considering moving to a risk-based payment arrangement, physicians who anticipate that a significant portion of their revenue will come from

risk-based payments in the future are well advised to undertake a more sophisticated analysis of the economics of their practices. Ask yourself, what other large industry manages itself by simply looking at the bottom line to know if it is working well? Few, if any, physician practices do much more than that. As new payment methodologies develop, knowing at the granular level which services you actually make money on and which you lose money on will become the norm. Without that data, the most likely response to less revenue will be for physicians to reduce their personal income as employee salaries, rent, malpractice costs and other costs of doing business are more difficult to control. With a good analysis, you will know what costs you can and cannot control, which payers are costing you money, which services are not the ones you should be providing, and whether you are being paid properly under the terms of your agreement.

If under the new payment model, your practice assumes risk for services it does not directly provide and refers those services to others, accruing IBNR (incurred but not reported) expenses, is not only critical but requires you to adopt accrual based accounting. Another lesson learned from past risk contracting experience is that not accurately managing IBNRs was one of the most likely reasons for physician practices to fail.

You will also need to be able to measure outcomes and quality. Today, most payers do that by data-mining claims to indirectly make those assessments. States are now creating "all payer claims databases" that combine data from multiple payers to be able to see a complete picture of your practice. You will need to be able to emulate their analytics, as well as develop your own for measuring what you believe is important. Here is a short list of concepts, approaches and things to consider in moving to the more sophisticated practice analysis you will likely need to thrive as payers increasingly move to "value-based" payment models.

1. Develop an internal analysis capability.
 - a. First, accept that Excel will not meet your needs.
 - b. Second, few if any practice management system (PMS) vendors do anything other than report frequency and quantity data. You will need to merge cost data, clinical data and be able to do statistical analysis of data not often found in PMS basic analytics. Thus, you may need to purchase a third-party analytics tool.
 - i. This will require hiring one or more competent analysts.

- ii. It will require the ability to extract data from the PMS and populate a relational database for you to do the necessary analysis and data mining. Depending on the size and complexity of your practice, the extractor alone can cost anywhere from \$15,000 to over \$100,000.
 - iii. Cost data from other systems like accounts payable, inventory management, HR and other sources will need to be extracted and defined in the relational database. Extraction tool costs will be incurred here as well. Your analysts may have to develop most of your reports from scratch.
- c. Some revenue cycle examples of the types of analytic reports you will need include:
 - i. Evaluation by CPT code for which you associated costs by linking direct costs (like supplies, pharmaceuticals, implantables, depreciation, etc.) and by doing step down allocations of indirect costs. Then you can specifically calculate your costs and associated revenues that will now distinctly highlight the positives and negatives.
 - ii. Direct cost allocations will be an unfamiliar process for most physician practices.
 - iii. It requires both an inventory management system that assigns costs to items, plus a workflow process that captures that data and associates it with the services provided.
 - vi. Step down allocation simply takes indirect costs and allocates them to predefined areas using rules to allocate percentages (or actual fixed costs) to given cost items/ areas that are then allocated to the associated services.

2. Different views

- a. How this data is sorted can give you different insights into what you are doing well and what needs to be scrutinized.
- b. Doing this for the whole practice is the first step. If there are items of concern, then other views like these may be needed:
 - i. By payer, by location can let you know if costs are more problematic in one area versus another.
 - ii. By physician can highlight that variance.

- iii. By payer, by physician can let you know if physicians have issues only for specific payers or it is a broader issue.
 - vi. By location, by physician can let you know if the negative variance in a location is driven by a particular physician(s).
 - v. The same example can be expanded by replacing physician by specialty, by ranges of CPT codes, and many other variables
 - c. Depending on your analytics software, each view is another report that needs to be developed or can be a different presentation of a larger report.
3. Dashboards and drill downs
- a. For physicians to have confidence in the new data, they need to be able to see it for themselves and create the different views (drill down, filter or re-sort) by themselves. This is accomplished by creating meaningful dashboards that allow for these different views.
 - i. The dashboards and reports physicians use to do this must require little training.
 - b. Ad hoc reports
 - i. No matter how good any report is, it will basically only help you formulate a question: "What is happening with 'X' that does not look the way I want?;" "Why does this area look better than another?;" "Why are my payments from that payer suddenly dropping?;" "Why are my costs for this service so high compared to the reimbursement I am receiving?"
 - ii. It is rare that a report also provides the answer without any workplace or environmental knowledge. Analysts should be able to help you formulate these high-level questions, and with your staff's input, postulate some reasons that may support an answer to the question. Ad hoc reports are then created to look specifically at data that support the reasons, if appropriate.
 - c. You will find that much of the value from your analytics will first come from your standard reports that create the general question(s) with ad hoc reporting providing the additional information that guides the formulation of the best answers.
4. Interpreting the data for practice improvement
- a. With the pressure from declining reimbursements and the increased complexity of the emerging payment models, the talent and experience needed to properly understand and respond to the data will itself become a new challenge for physician practices.
 - i. Adjusting contract terms—You will need to be armed with more than the observation that your costs are above your payments. You will need to show that your costs cannot be further reduced, that you are meeting quality and outcome expectations (with the reports that support that), and the reasons for the cost variances that are impacting the practice.
 - ii. Possible dropping of some services—You may find that others in your area are not having the same cost challenges for certain services and you may need to consider no longer providing them.
 - 1. Rather than providing the flu shot, directing your patients to go to the pharmacy.
 - 2. Referring patients for ancillary services that you can no longer provide in a cost effective manner.
 - 3. Closing an office in an area where rental costs are too high.
 - 4. Joining a purchasing group – buying office and medical supplies on your own may no longer be the way to go.
 - 5. Replacing some physicians with nurse practitioners, physician assistants or other limited license professionals – if payers have attractive contract terms that support this alternative, you will need to evaluate it.
5. Risks—creating the metadata definitions and cross-mapping from disparate systems is always a bigger challenge than expected.
- a. Populating the database is easy.
 - b. Associating the data meaningfully is not.
 - c. Trust your instincts. If your reports clearly state something that does not look right to you, it may be that your data definitions/mappings maybe the root cause creating results that do not seem correct, so double check them.

6. The need for an accounting platform that does accrual-based accounting.
 - a. As noted above, not accounting for expenses that you have not yet received an invoice often invites physician practices to issue bonuses as their bank account is overflowing. Later, when the large, unrecognized expenses come in, there may be no funds to cover them in a capitated (or similar) environment.
 - b. Accrual-based accounting will also require you to recognize revenue when billed, rather than when received. The amount recognized is adjusted by historical contractual adjustments and bad debt that you have experienced.
 - i. These historical adjustments need to be evaluated regularly and kept up to date.
 - ii. The new accounting practices may require you to retrain or even replace existing staff who are unfamiliar with it.
 - iii. As part of this IBNR process, you should build a grid for what you are responsible for, what your organization has sub-capitated, and/or what the payer is still responsible for (a Division of Financial Responsibility report). Have the payer sign off on the accuracy and completeness of this DOFR. See the chapter entitled "Capitation," for more discussion of DOFRs, as well as a sample DOFR form.
7. Using the data for new payment methodologies—capitation, bundled payments, shared savings arrangements, etc.
 - a. The AMA recommends that you require the payer to provide you with a minimum set of reports you will need before you agree to any risk-based contract. It is important for you to have expert advice here, not only for what these reports should contain, but guiding your analytics staff to create similar reports so you can independently verify what the payer represents in its reports.
 - b. Restating the reimbursements you get into a usable benchmark that meets your needs is important for the practice to assess its performance under these new reimbursement approaches. At this time, the most common recommended benchmark is to create FFS equivalents of the data. One approach to do that is to:
 - i. Continue posting to your PMS all of the individual services as if you were going to bill them as FFS.
 - ii. Calculate the historical revenue per tRVU for these services.
 - iii. Calculate the tRVUs for the new services, regardless of how they are reimbursed. Divide the payments plus bonuses you receive for those services, less non-practice expenses like referrals you have to pay by the associated tRVUs (where you have assumed payment responsibility for services that will be performed by others), and likewise calculate revenue per tRVU and compare. For even more accuracy, you can adjust for the changes in the particular RVU values that ordinarily occur over time so that those changes do not skew the data.
 - vi. You must be able to calculate your payments pursuant to each risk-based payment arrangement as a FFS equivalent or revenue and expenses per total RVU so as to make assessments that can be compared to historical experience, at least as you are transitioning.
8. Outsource the analytics to a trusted source
 - a. The type and breadth of the robust analytics you may require can quickly appear daunting and too expensive.
 - b. Experienced and well-qualified analysts who can not only help you create the reports and dashboards you need, but also help you interpret the results, are a scarce resource. Even if available, they can be expensive.
 - c. With the success of cloud-based and Software as a Service (SAAS) strategies, you may wish to explore partnering with a third party who can provide turnkey services with no capital investment (just monthly fees).
 - d. Even if this is your choice, the retention of an actuarial expert is still recommended if you are considering any budget-based payment arrangement, such as capitation, shared-savings or bundling, where your financial success is dependent on your ability to keep your costs within a specified budgeted amount.
9. Clinical analytics
 - a. Capturing the data your payer uses from claims data to assess your performance is the next step

after you are satisfied with your revenue cycle efforts.

- b. Since this is an emerging area, you may wish to also partner with third parties to provide these analytics for you, in addition to any internal analytics you develop.
- c. The challenge may not be in emulating internally how a payer creates reports, but rather in integrating that data with cost data and data you do not have.
 - i. You need to know if you have positive outcomes and quality but you are losing money.
 - ii. You need to know pharmaceutical costs and other costs your payer sees that you do not. Consider getting that data from your payer, a pharmacy benefit manager (PBM), or from all payer claims databases.

Conclusion

As this brief outline indicates, physicians with a sophisticated understanding of their practices' financial and clinical analytics will be best positioned to manage the changing payment environment. While many practices will ultimately want to pursue very robust evaluation and monitoring systems, even small physician practices will benefit from doing the basic evaluation of their costs discussed at the beginning of this chapter. In no event should physicians embark on new payment arrangements without understanding what the likely financial impact of those arrangements are likely to be.