Chapter 1 Providing Services to Physicians and Other Health Care Professionals—an Introduction

100 Introduction

100.1 Physicians and other health care professionals present both an opportunity and a challenge for practitioners who wish to provide them services. The opportunity lies in the fact that this market is unique, very large, and ever growing. Practitioners who successfully enter this market often find it to be a significant and highly profitable portion of their practice. The challenge lies in being able to provide a wide range of services in an ever-changing industry to meet the physician's needs. These clients may require everything from consultation on starting or changing their practice as a result of managed care to help in planning for their retirement needs. The successful practitioner is able to provide these services quickly and at a reasonable cost.

100.2 In this Guide, the authors provide both the technical guidance and practical advice needed to successfully serve physicians and other health care professionals. Covered is everything from the basic guidance needed to compile financial statements to an overview of what should be known about a wide variety of consulting services. This chapter introduces the basics that serve as the foundation for the topics discussed throughout the remainder of this Guide. It covers what is meant by health care professionals, the current status of the health care industry, the Health Care Reform Acts, services that can be provided by practitioners, how to build a successful practice, and the characteristics of a successful practice.
101 Who Are Physicians and Other Health Care Professionals?

101.1 Physicians and other health care professionals are those professionals who practice in the medical industry and provide some form of treatment to improve or maintain the physical or emotional well-being of their patients. When thinking of health care professionals, many people think first of medical doctors or physicians. In this Guide, as a matter of convenience and clarity, the authors use the term physicians when referring to those health care professionals to whom practitioners commonly provide services. This should not, however, be considered a restrictive definition. The health care professionals to whom practitioners provide services, and on whom this Guide focuses, encompass a wide range of professions. These include, but are not restricted to:

a. Medical doctors (including the many specialties).

b. Dentists.

c. Orthodontists.

d. Optometrists.

e. Podiatrists.

f. Psychologists.
Continuing Care versus Incident Practices

101.2 One way of classifying practices that is helpful is continuing care and incident practices. Continuing care practices are those where there is a long-term relationship with the patient such as internal medicine, cardiology, family practice, OB-GYN, psychiatrists, psychologists, etc. Incident practices are those where there is little possibility of such long-term relationship and includes neurosurgery, urology, plastic surgery, general surgery, orthopedic surgery, etc. The management challenges of dealing with patients, collecting accounts, etc. are very different for continuing care and incident practices. For example, incident care practices have less opportunity for identifying and eliminating slow-paying patients.

101.3 Most practices are a combination of continuing care and incident practices; very seldom will a practice be exclusively one or the other.

Hospital-based versus Office-based Physicians

101.4 A second useful distinction is hospital-based and office-based. Hospital-based physicians (radiology, pathology, and anesthesiology) frequently are not required to have staff employees but are supported entirely by the hospital. The problems of hospital-based physicians are different and usually less complex than those of office-based physicians, who tend to have larger staffs, provide some ancillary services, and have a higher traffic volume.
102 Status of the Health Care Industry

102.1 The health care industry is constantly changing as providers attempt to reduce costs and provide services more efficiently. Medicare reform, government regulations, reductions in federal funding for states, and the growth of managed care have created a highly competitive market. The implementation of electronic health records—digitizing the nation's mass of paper medical files—is underway and is expected to revolutionize health care delivery, reduce errors, and save money. This effort is being championed by both the U.S. Department of Health and Human Services (HHS) and Congress and may result in a federal mandate if the health care industry hesitates in the process. The American Recovery and Reinvestment Act of 2009 included $19 billion for health care information technology investment through the portion of the legislation called the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. Also, as discussed in paragraph 102.7, the current administration is focused on overall health care reform. Now more than ever, a physician’s success depends on the ability to anticipate change and respond appropriately. There are several federal and state laws and regulations that impact the practice of medicine.

Managed Care

102.2 The majority of Americans with health care coverage now receive benefits through some sort of managed care arrangement; however, the much-maligned Health Maintenance Organizations (HMO) have taken a back seat to more popular Preferred Provider Organizations (PPO) and Point of Service (POS) plans. The growth of managed care has changed the health care environment, perhaps more than any other factor. It has led to dramatic changes in health care delivery ranging from how services are reimbursed to when and what medical services are provided. Managed care organizations, which are predicted to become the dominant form of health care delivery throughout the United States, have created nontraditional physician arrangements by shifting the focus of reimbursement from fee-for-service to capitation or some other risk sharing mechanism. In short, purchasers of health care services have come to expect providers to assume some financial risk for treating the growing population of patients.

102.3 In response to increased competition and declining profitability under managed care, physicians are affiliating in integrated delivery systems that include any combination of outpatient, inpatient, and physician services. In some cases, however, integrated delivery systems have brought about their own set of problems.
They can sometimes be complex and difficult to manage due to the different objectives and concerns of various affiliated physicians. Sections 1206 and 1210 provide a discussion of managed care.

**Medicare Reimbursement**

102.4 Medicare pays for a large portion of the fees charged by many physicians. It is the largest single payor of all personal health care expenditures. Although the much discussed health care reform effort of the early 1990s did not result in comprehensive health care reform legislation, Congress continued to consider comprehensive Medicare reform. One example of health care reform legislation is the Medicare Legislation contained in the Balanced Budget Act of 1997. That legislation resulted in the overhaul of Medicare managed care through implementation of the Medicare Advantage program. Another example is the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (discussed in paragraph 102.7). The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively the “Health Care Reform Acts”) included major changes for Medicare that will be implemented over a 10 year period (discussed in section 103). In any event, Medicare regulations are constantly changing in an effort to reduce long-term spending without reducing benefits or increasing fees to beneficiaries. The end result—physicians who provide medical services to Medicare patients will continue to face reduced reimbursement.

**Stark III Regulations**

102.5 Centers for Medicare and Medicaid Services (CMS) published the final regulations for the Stark III rules in the September 5, 2007 Federal Register. Stark III is the third phase of the rules implementing the physician self-referral law. CMS did not propose any new Stark exceptions in the Stark III rules, but CMS did refine the existing exceptions. A significant change in this set of rules was the requirement that a physician “stand in the shoes” of his or her group practice. Consequently, arrangements previously considered as indirect compensation arrangements are now considered direct compensation arrangements. The following Stark regulations were also clarified by the Stark III regulations:

- Physician recruitment.
- Retention payments in underserved areas.
- Rental of office space and equipment.
- Personal services arrangements.
- Nonmonetary compensation.
• Professional courtesy.

• Charitable donations by a physician.

• Compliance training.

• Fair market value compensation.

Medical Information Sharing

102.6 The Patient Safety and Quality Improvement Act of 2005 enables the accumulation of more accurate information about medical treatments with the goal of reducing medical errors. To accomplish this, the bill creates a confidential system for voluntary reporting of medical errors by health care providers. Because the reports are confidential, the information reported cannot be used against health care providers in civil and criminal proceedings. In November 2008, the Agency for Healthcare Research and Quality (AHRQ) published the Patient Safety and Quality Improvement final rule (Patient Safety Rule) that became effective on January 19, 2009. The Patient Safety Rule establishes a framework for reporting information for analysis of patient safety events, outlines the requirements that entities must meet to become Patient Safety Organizations (PSOs), and establishes the processes for the AHRQ to review and accept certifications and list PSOs.

Medicare Reform

102.7 On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was signed into law. Some of the provisions of this highly complex legislation include the following: increased reimbursement rates for physicians, incentives to providers for practicing in designated underserved rural and urban areas, expansion of coverage for preventative services, introduction of a voluntary prescription drug plan, and the establishment of Health Savings Accounts (HSAs) for eligible individuals with qualified high-deductible health plans, regardless of age.

102.8 The MMA directed the HHS to establish a demonstration program to determine if the use of recovery audit contractors (RAC) to identify Medicare underpayments and overpayments and recover Medicare overpayments is cost effective. The RAC demonstration program proved to be successful in returning funds to the Medicare trust funds and identified amounts to return to providers. In July 2008, the CMS released an evaluation report showing that nearly $700 million in improper Medicare payments was returned during the demonstration program through March 2008. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and expanded the RAC program that is now implemented in all 50 states.
Health Savings Accounts

102.9 HSAs operate like IRAs and allow eligible individuals to make a tax-deductible contribution to cover the cost of the deductible of a qualified high-deductible policy. To be eligible to make a contribution, the individual must have a deductible of at least $1,200 in 2012 and $1,250 in 2013 for single coverage and $2,400 in 2012 and $2,500 in 2013 for family coverage. For 2013, the contribution is $3,250 for single coverage or $6,450 for family coverage. These amounts are inflation adjusted each year. HSAs are discussed further at paragraph 707.13.

Economic Crisis Impact

102.10 Like most industries, the health care industry was impacted by the global economic crisis with investment securities declines, liquidity and funding concerns, and payment reductions as well as increased charity care requests and government scrutiny. In response to the economic crisis and subsequent recovery, the AICPA created a going concern whitepaper, Current Economic Crisis: Going Concern Considerations—2012, to provide auditors an overview of their responsibilities when considering the entity's ability to continue as a going concern (see http://www.aicpa.org/interestareas/frc/pages/currenteconomiccrisisgoingconcern.aspx). In addition, the AICPA issued an Audit Risk Alert, General Accounting and Auditing Developments—2011/2012, that while audit-focused, may still enhance the practitioner's understanding of issues affecting the health care industry. The AICPA Audit Risk Alert, Health Care Industry Developments—2011/2012, also discusses economic and industry developments specific to the health care industry. These publications are available on Checkpoint to subscribers of the AICPA material, online (electronic or print version) at www.cpa2biz.com, or by calling the AICPA at (888) 777-7077.

102.11 Government Responses

The American Recovery and Reinvestment Act of 2009 is a $787 billion economic stimulus package that includes significant funds dedicated to health care related spending. States received $87 billion in additional Medicaid funding. Health care information technology, primarily for computerized medical records, receives $19 billion in funding through Medicare and Medicaid incentives as well as grants and loans. An additional $1.1 billion will be used for research to compare the effectiveness of medications and medical devices. The White House and the HHS each established an Office of Health Reform to coordinate efforts to develop policies on health care across executive departments and agencies and to control the growth of health care costs. See www.healthcare.gov for additional information about the health care reform initiatives.
103 Health Care Reform Acts

103.1 The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively the “Health Care Reform Acts”) combine to dramatically change how health care is delivered in the United States. Both were enacted in March 2010 and will be implemented over the next several years. Many provisions of the Health Care Reform Acts will affect employers and employer-provided health plans immediately and over the next decade. The Health Care Reform Acts will also affect organizations throughout the health care industry in many ways through insurance reforms, changes in Medicare and Medicaid provider payments, quality and transparency initiatives, and delivery system reforms.

103.2 The purpose of the Health Care Reform Acts is to provide at least minimum health care benefits to all individuals. The legislation provides for the establishment of qualified health plans that must provide an essential health benefits package. The Congressional Budget Office (CBO) estimates that about 32 million people will become insured by 2019, although more than 20 million of these will be in Medicaid. The CBO also estimates that the Health Care Reform Acts will cost approximately $940 billion over a ten-year period.

103.3 The Health Care Reform Acts are expected to be funded from new taxes and fees, reduced provider payments that in turn are expected to be offset by revenue from the newly insured, and assumed reduction in fraud in the Medicare and Medicaid reimbursement systems. The reduction in provider payments is discussed beginning at paragraph 103.13 and the impact from eliminating fraud and waste is discussed at paragraph 103.26. New taxes and fees come from a wide variety of sources. A 40% excise tax will be placed on “high dollar” health insurance plans; practitioners should be aware that because of cost of living and intensity of service utilization differences, among other factors, this excise tax falls disproportionately among the states. Medicare payroll taxes paid by the upper middle class and wealthy is increased and will include both earned and unearned income in the base. The threshold for itemized medical expense deductions increases from 7.5% to 10%. Indoor tanning services have an additional 10% tax that is already implemented. Beginning in 2011, an annual, non-deductible fee on pharmaceutical companies are assessed based on each company's share of the gross receipts of the pharmaceutical manufacturing industry for the prior year multiplied by a fixed amount. In 2013, a 2.9% excise tax is placed on the first sale for use of a medical device. In 2014, an annual, non-deductible fee on health insurance providers will be allocated according to market share within the health
insurance sector. The tax deduction for the subsidized portion of retiree Medicare Part D prescription drug payments will be eliminated for years beginning after December 31, 2012.

103.4 The tax implications of the Health Care Reform Acts are beyond the scope of this Guide. PPC's Guide to Health Care Reform is designed to provide tax-related guidance to the tax professional, employer, plan sponsor, and others who must deal with the business and tax aspects of the health care reform legislation.

103.5 The federal health care reform legislation is very closely modeled on the Massachusetts reform legislation that was passed in 2006. As such, practitioners who need to advise their clients about the likely impact of federal health care reform on small businesses in particular should consider studying the results in Massachusetts. In September 2010, the nonpartisan Center for Studying Health System Change released a report reviewing the Massachusetts experience that can be obtained at http://hschange.org.

Insurance Reform

103.6 While labeled as health care reform, much of the impact of the Health Care Reform Acts will be through changes in the insurance market. By 2014, most residents of the United States will be required to obtain health insurance or pay a penalty, which was upheld by the Supreme Court in June 2012. The tax on individuals without qualifying coverage will start with a minimal penalty but will grow to $695 per year or 2.5% of household income by 2016. The penalty amount remains less than the comparable penalty in the state of Massachusetts upon which the federal reform was modeled. This penalty will also likely be substantially lower than the cost of obtaining health insurance. Businesses with more than 50 full-time-equivalent (FTE) employees will be required to pay a flat fee of $2,000 annually per uncovered FTE employee receiving eligibility subsidies starting in 2014 (the first 30 FTE employees are subtracted out of the fee determination). Employers with more than 200 employees are required to automatically enroll employees into the health insurance plans offered by the employer—though the employee may opt out of the coverage. Medicaid will be expanded in 2014 to be available to citizens who earn less than 138% of the poverty level. (Note: The Health Care Reform Acts actually state that the level is 133% but it is, in fact, 138% because a separate provision in the legislation provides for a 5% disregard in the income calculation.) Much of this expansion will be to adults without dependent children who are presently excluded from Medicaid coverage in most states.

103.7 During the first year of implementation, the primary impact on insurers will include the following:

- Plans must cover adult dependent children up to age 26.

- A temporary national high risk pool will be established for people who are uninsured for at least six months due to pre-existing conditions.

- Insurers are precluded from denying coverage to children with pre-existing conditions.
• Insurers are precluded from placing lifetime limits on the dollar value of coverage.

• Insurers are precluded from denying or rescinding coverage of insured persons who become sick, except for instances of fraud by the insured.

• All “new” plans will provide first dollar coverage for preventative services and immunizations. As described in paragraph 103.12, existing plans which undergo what may be seen as common changes will be considered “new” under interim regulations issued in June 2010.

103.8 The insurance reforms include the following:

• Group plans must spend a certain percentage of premium dollars on medical services (85% for large plans and 80% for small plans) with rebates to customers of plans that spend less on medical services.

• Health insurance “exchanges” in each state will be open to individuals and small employers with up to 100 employees. Exchanges are modeled on the Massachusetts Health Connector, a web portal where insurers offer health insurance to consumers. The Office of Personnel Management will also contract with insurers to offer multi-state plans.

• Health insurance regulations will be revised to prohibit insurance companies from engaging in discriminatory practices due to an individual’s health status, to limit the ability of insurance companies to charge higher rates due to health status (e.g., pre-existing conditions), gender, or other factors, and to only vary premiums on age, geography, family size, and tobacco use based on specific numeric factors. For example, age-based premium differences cannot exceed 3.0 and tobacco use differences cannot exceed 1.5.

• Health plans will be prohibited from imposing annual limits on the amount of benefits an individual may receive.

103.9 For plan years beginning after 2013, health plans that are not grandfathered (generally these are group health plans in existence on March 23, 2010; however, see the discussion at paragraph 103.12) must be qualified health plans. A qualified health plan meets certain certification criteria that will be established by the Health and Human Services Department (HHS), provides an essential health benefits package, and is offered
by a licensed health insurance insurer that meets certain criteria. Grandfathered plans are deemed to be qualified health plans.

103.10 An essential health benefits package is coverage that:

a. provides minimum essential coverage,

b. limits cost-sharing for the minimum essential coverage, and

c. provides a level of coverage that is actuarially equivalent to 60% (bronze), 70% (silver), 80% (gold), or 90% (platinum).

103.11 The minimum essential coverage that a qualified health plan must offer are the items and services covered in the following categories, the specific terms of which are to be defined in yet-to-be-released regulations:

• Ambulatory patient services.

• Emergency services.

• Hospitalization.

• Maternity and newborn care.

• Mental health and substance use disorder services, including behavioral health treatment.

• Prescription drugs.

• Rehabilitative and habilitative services and devices.
• Laboratory services.

• Preventive and wellness services and chronic disease management.

• Pediatric services, including oral and vision care.

103.12 The following are examples of the types of changes that can cause loss of grandfathered status:

a. Entering into a new policy, certificate, or contract of insurance after March 23, 2010 including simply changing the insurer (subsequent regulations in November 2010 modified this last provision so that merely changing insurers or policies, not policy terms, did not end grandfather status).

b. Eliminating all or substantially all benefits to diagnose or treat a particular condition (for example, eliminating all benefits for In Vitro fertilization).

c. Increasing the fixed-amount and percentage cost-sharing by more than specified amounts to reflect medical inflation.

d. Decreasing the employer contribution rate for coverage by more than 5%, such as decreasing the employer-paid share of premium from 75% to 65%.

e. Imposing a new or modified annual limit on benefits.

Provider Payments

103.13 According to the Congressional Budget Office (CBO), over the 2010-2019 period, changes in the rates-of-increase to Medicare providers will reduce payments to providers by around $500 billion or approximately half of the cost of the reform. The yearly updates to Medicare’s market basket growth amounts are reduced by varying rates each year for inpatient and outpatient hospital charges, inpatient rehabilitation facilities, long-term care hospitals, and home health outlier and rural add-on payments. Medicare Advantage payments are reduced to the level of payments made in fee-for-service plans. A productivity adjustment will be introduced with the potential for rates becoming negative.
103.14 Practitioners should be aware that the CBO is required to follow instructions from Congress when scoring legislation and those instructions may be counter to the likely outcome. The Chief Actuary of the Centers for Medicare and Medicaid (CMS) had the following comment with respect to the productivity adjustment in his April 22, 2010 "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended:"

"It is important to note that the estimated savings shown in this memorandum for one category of Medicare provisions may be unrealistic. The PPACA introduces permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide private, non-farm productivity gains. While such payment update reductions will create a strong incentive for providers to maximize efficiency, it is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large. Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments. Although this policy could be monitored over time to avoid such an outcome, changes would likely result in smaller actual savings than shown here for these provisions."

Practitioners will also need to monitor legislative developments as the cost saving provisions used by the CBO can be modified in future legislation, and are likely to be so modified.

103.15 Medicare Payments to Hospitals

Medicare payment updates incorporate productivity adjustments for prospective payment system hospitals starting in 2010, resulting in a budgeted payment reduction over ten years of approximately $112.6 billion. Medicare payments are also increased for hospitals in counties in the lowest quartile of per capita Medicare spending (generally starting in 2011) and will be decreased for hospitals with high readmission rates (generally starting in 2013) and hospitals with a high rate of hospital acquired conditions (generally starting in 2015).

103.16 Medicare Disproportionate Share (DSH) payments are made to hospitals who serve large numbers of Medicaid and indigent individuals in order to compensate them for the otherwise poorly reimbursed care. DSH payments will be reduced as the number of uninsured patients is reduced (generally starting in 2014) as Medicaid expansion to presently uncovered populations takes hold. Medicaid DSH payments will also be reduced over 10 years beginning in 2014.

103.17 Medicare Payments to Physicians

Centers for Medicare and Medicaid Services (CMS) is directed to increase incentive payments under the Physician Quality Reporting Initiative (PQRI) program and the PQRI program is extended through at least
2014. Beginning in 2015, a penalty will be imposed on physicians who do not participate in the program. The Health Care Reform Acts provide for a 10% bonus payment to primary care physicians (PCP) as well as primary care providing physician assistants and nurse practitioners. A separate provision provides a 10% bonus to general surgeons for select services provided in health professional shortage areas (generally starting in 2011).

103.18 The primary care bonus provision is one of the most significant for practitioners working with physician clients. PCPs are defined as physicians specializing in family medicine, internal medicine, geriatric medicine, and pediatric medicine if at least 60% of total Medicare Allowed Charges are for office, skilled nursing facility (SNF), home, rest home, and other visits specified by CPT Codes. For 2011 through 2015, eligible PCPs will receive a bonus equal to 10% of Medicare payments for these services. CMS stated that half of the cost of the bonuses would be offset through an across-the-board reduction in all other services and this is important to point out to non-PCP clients.

103.19 The relevant CPT™ codes are:

a. Office - new and established patients visits—99201 through 99215 (the most common codes).

b. Nursing facility visits—99304 through 99340.

c. Home visits—99341 through 99350.

103.20 Practitioners should be aware that when physicians and other providers register with CMS they designate their specialty, e.g., internal medicine. Physicians who are not registered with CMS as specializing in family medicine, internal medicine, geriatric medicine, or pediatric medicine will not be eligible for this bonus, even if they meet the other criteria. CMS indicated in the 2011 Proposed Rule released in June 2010 that it will prevent physicians currently designated as other than PCPs from attempting to change their specialty designation in order to be eligible for the bonus payment. CMS also indicated that PCPs located in a Health Professional Shortage Area (HPSA) would be eligible for a 10% payment bonus based upon the regular Medicare fee schedule in addition to the HPSA payment; however, the HPSA payment itself would not be increased by the 10%.

103.21 Medicare will also expand its present coverage for a one-time initial preventive physical when a beneficiary becomes eligible for Medicare. Effective January 11, 2011, annual preventive medicine visits will be covered, which are to include personalized prevention plan services. CMS has developed two new HCPCS G Codes to report the first preventive medicine visit and subsequent visits. Oddly enough, the addition of preventive medicine services, a key primary care service, to Medicare may cause many PCPs to fall short of the 60% threshold required for the 10% primary care bonus. The authors have already seen this occur in many otherwise pure primary care practices due to their emphasis on preventive medicine.

103.22 Independent Payment Advisory Board
Starting in 2015, HHS will establish an Independent Payment Advisory Board to develop and submit proposals to Congress and the private sector with the goals of extending the solvency of Medicare, lowering health care costs, improving health outcomes for patients, promoting quality and efficiency, and expanding access to evidence-based care. This commission will have Medicare rate-setting authority and proposals will be automatically implemented unless Congress acts in opposition. However, hospitals are exempt from the commission’s recommendations until 2020 and other providers with update reductions will also be exempt until 2019.


Delivery System Reforms

103.24 Accountable Care Organizations and Medical Home Models

Groups of eligible providers that meet certain statutory criteria, as well as those in the final regulations issued in November 2011, may be recognized as accountable care organizations (ACOs) that are eligible to share in the cost savings, or shared savings, expected to be realized by the Medicare program. To qualify as an ACO, a group of providers must meet the detailed requirements specified in the regulations, including having a minimum of 5,000 Medicare beneficiaries covered by its participants, and have established a mechanism for joint decision-making, risk-sharing, financial responsibility for any losses, and meeting quality performance standards. An ACO, may include group medical practices, provider networks, physician-hospital joint ventures, and others. A three-year commitment by the ACO to the shared savings program is required. Two tracks are offered in the regulations, with the first track having no risk of loss during the initial three-year commitment and a maximum percentage of shared savings of 50%. The second track requires exposure to losses from the outset of the agreement but has a maximum percentage of shared savings of 60%. Special demonstration projects will be established through the Medicaid program to promote the provisions of care by pediatric medical providers and study the use of bundled payments for hospital and physician services. Finally, HHS will award grants to providers for the development of medical home models of care. See further discussion of ACOs in Chapter 5.

103.25 Bundled Payments

In addition to establishing incentives for the creation of ACOs, HHS will develop a Medicare bundled payment pilot program offering incentives to providers who coordinate care (generally starting in 2013). The bundled payment will be for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to the hospitalization and spans 30 days following discharge. This program will be complemented by a four-year demonstration project (from 2012 to 2016) to study the use of bundled payments for hospital and physician services in eight states through the Medicaid program.

Quality and Transparency Initiatives

103.26 Medicare Fraud and Abuse
As a condition of enrollment in Medicare, Medicaid, and/or Children’s Health Insurance Program (CHIP), all providers and suppliers who do not already have compliance programs must implement such programs. Basic elements of a compliance program are to be developed by HHS. Medicare and Medicaid overpayments must be reported and returned within 60 days of the identification of the overpayment or the date a corresponding cost report is due, whichever is later. Providers are required to report the reason for the overpayment in writing. A provider’s failure to report an overpayment is considered an obligation for the purpose of the False Claims Act, which may result in liability against a provider for retaining an obligation. Increased civil monetary penalties and other forms of sanction will be available to CMS in enforcing fraud and abuse prohibitions, and the Health Care Fraud and Abuse Control Fund will receive increased funding for screening and enforcement activity. Practitioners should note that the 60 day overpayment rule is one of the more dramatic provisions in the legislation and has implications across a variety of accounting disciplines, including valuation, auditing, and financial statement preparation.

103.27 Quality Initiatives

HHS will receive additional resources to augment its current quality reporting program to aide in the development of new quality measures and to establish national priorities for quality improvement programs through a new innovation center and other methods. Existing quality reporting programs will be expanded to include a broader range of service providers and the value-based purchasing program for in-patient hospitals will be expanded. ACOs are the first innovation and include 33 quality measures under which participants are evaluated.

103.28 By the end of 2012, HHS is required to submit a plan on how to move home health and nursing home providers into a value-based purchasing program system. Also on October 1, 2012 the program for acute care hospitals transitions from pay-for-reporting to pay-for-performance and reduced payments to hospitals with high readmission rates begins. A percentage of hospital payment will be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical, and pneumonia care. In 2013, the actual payment linked to quality outcomes will become effective and will be funded by an across-the-board cut in every hospital's base payment. If implemented in accord with the legislation, the combination of these pay-for-performance changes with the productivity adjustment described at paragraph 103.15 are estimated to put as much as 6% of a hospital's DRG payment at risk. Quality performance measures starting in 2013 include evaluation of treatment of acute myocardial infarction heart failure, pneumonia, and surgeries, as measured by the Surgical Care Improvement Project and healthcare-associated infections, as measured by the HHS Action Plan to Prevent Healthcare-Associated Infections. As is the case increasingly throughout the Medicare and Medicaid payment systems, measures of patients’ satisfaction with the level of care will be measured using the hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey metrics.

103.29 Prevention and Wellness Initiatives

The Health Care Reform Acts provide for the establishment of the Prevention and Public Health Fund and a Community Health Center Fund. These funds are intended to help finance disease prevention and public health programs, community-based programs that promote healthy lifestyles (particularly in medically underserved areas), patient education and outreach efforts, and develop demonstration programs that may

https://checkpoint.riag.com/app/view/toolItem?usid=bc03cv247c8d&feature=ttoc&lastCp...
test innovative approaches to reducing chronic diseases. A special ten-state pilot project will test the impact of providing wellness programs to at-risk communities including nutrition counseling, physical activity plans, and smoking cessation programs.

**Other Requirements**

**103.30 Stark Law Amendments**

Physicians or group practices that provide in-office MRI, CAT scan, or PET scan services (and potentially other radiology services) must now inform patients, in writing, that these services may be obtained elsewhere. This written disclosure must be made at the time that the referral is made, and must be accompanied by a written list of suppliers who furnish these services in the area in which the patient resides. This new requirement was effective immediately. See further discussion of the impact of the Health Care Reform Acts on the Stark laws in section 1209.

**103.31 Manufacturers and Nursing Home Disclosure Requirements**

Generally starting in 2013, drug companies and device manufacturers will have to disclose payments to physicians. Nursing homes will have to provide public disclosure of ownership information, develop compliance programs, and implement staff training programs.

**103.32 Rebuilding Primary Care Workforce Incentives**

In order to strengthen the availability of primary care with the influx of newly covered patients, the legislation includes incentives to expand the number of primary care doctors, nurses, and physician assistants. The incentives include funding for scholarships and loan repayments for primary doctors and nurses with the intention of increasing the availability of health care services in underserved areas or health professional shortage areas.

103.33 Exhibit 1-2 includes various sources of information on health care reform.

**Exhibit 1-1**

**Sources of Additional Information on Health Care Reform**


- Massachusetts Division of Healthcare Finance & Policy—


• Kaiser Family Foundation Subsidy Calculator—http://healthreform.kff.org/Subsidycalculator.aspx. This is a tool which enables users to calculate what government subsidy for health insurance is available to an individual or family based upon age, income, and family size.


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1 Additional information on CAHPS surveys and tools is available at https://www.cahps.ahrq.gov/default.asp.

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104 Services Provided by Practitioners

104.1 In many respects, a health care practice is like any other business. It is profit motivated and must be economically viable if it is to continue in existence. In other respects, however, these practices are unique. Most health care professionals, appropriately, consider their first priority to be providing quality service to their patients. Consequently, their training is focused on their profession, not on running a business. The profit motive is a necessary, but secondary, concern. This is where practitioners can provide an invaluable service by making use of their business knowledge. These services can generally be divided into two categories—practice services and personal services.

Practice Services

104.2 Practice services are provided to help establish and maintain a viable business. They are similar to the services provided to most small businesses and include:

a. Selecting the appropriate form of entity (sole proprietorship, partnership, or professional corporation).

b. Providing personnel management services.

c. Selecting the appropriate accounting system.

d. Implementing and monitoring the accounting system.

e. Providing bookkeeping services.
f. Providing payroll services.

g. Managing accounts receivable.

h. Preparing financial statements.

i. Preparing tax returns.

j. Assisting in establishing banking relationships.

k. Assisting in obtaining financing.

l. Assisting new medical practices.

m. Developing marketing strategies.

n. Assisting in adding physicians to a medical practice.

o. Assisting with practice affiliations.


q. Reviewing risk management policies.

r. Understanding government regulations.
s. Designing systems for maintaining medical records.

t. Designing appointment systems.

u. Performing revenue management reviews.

v. Negotiating and evaluating managed care arrangements.

**Personal Services**

104.3 Personal services are those provided to the professional personally. They are similar to the services provided to many individuals and include:

a. Investment planning and advice.

b. Retirement planning.

c. Estate and gift tax planning.

d. Preparing personal tax returns.

e. Preparing personal financial statements.

104.4 Because the health care professional is so closely involved with the practice, personal services and practice services often overlap. For this reason, practitioners are presented with a unique opportunity to use all facets of their own practices. Since the services may range from ongoing bookkeeping to personal investment advice, firm personnel from paraprofessionals to new staff to the engagement partner can be involved. The advent of managed care also presents practitioners with unique consulting opportunities.
104.5 Another common service opportunity for health care professionals involves related entities. Successful health care professionals will often be involved in outside investments and partnerships. Practitioners’ services related to these entities can range from organization advice to tax consulting to ongoing accounting and tax work.
105 Building a Successful Practice

105.1 A practice that is successful in providing services to health care professionals requires planning. The authors recommend an approach that includes the following steps:

a. Determine the services to be offered.

b. Evaluate the firm’s capabilities.

c. Analyze the competition.

d. Identify the target market.

e. Develop a marketing strategy.

f. Select specific marketing methods.

105.2 In the following paragraphs, each of these steps is explained separately but, in implementation, aspects of these steps are performed concurrently.

Determine the Services to Be Offered

105.3 The first step is to determine what services the firm will offer. One of the keys to building a successful health care practice is to broadly define the roll of the accountant as adviser in most, if not all, of the areas
listed in section 104. Health care professionals ordinarily look to their accountants for advice in all business aspects of the practice, and they will not be satisfied with practitioners who can provide only limited services. Initially, however, the firm may not have the capability to provide all of those services. In that case, the firm may decide to first provide only one or a few services, such as bookkeeping and payroll. This “foot in the door” can then serve as a base for expanding the number of services provided. This approach should be viewed only as an intermediate step to becoming a full-service advisor. The firm may find it difficult to obtain new clients if it cannot offer all of the services needed.

105.4 Sole Practitioners and Small Firms

Notwithstanding the guidance in the preceding paragraph, some sole practitioners and small firms have successfully developed niche practices by focusing solely on services in which they have specialized knowledge or experience, e.g., accounts receivable analysis, tax planning for physicians, compilation engagements, etc. Niche practices can also be developed by firms new to the health care industry. For example, developing expertise in billing, patient coding, and other health care specific areas, such as managed care arrangements, can set a firm apart from its competition without a significant investment in time and training.

105.5 AICPA Special Committee on Assurance Services

Several years ago, the AICPA Special Committee on Assurance Services was created to explore new ways for CPA firms to grow. Because the market for many traditional services has matured, the committee looked for service opportunities to better position the profession for the future. The committee report identified 13 specific services. Although those services cover a wide spectrum of service types, the following services may have a common bond with serving health care providers or patients of those providers:

a. Health Care Performance Measurement. This service provides assurance about the effectiveness of health care services provided by HMOs, hospitals, doctors and other providers. This service would appear to be a natural outgrowth for CPAs that understand the health care industry.

b. ElderCare. ElderCare assesses whether specified goals regarding care for the elderly are being met by various caregivers.

c. Information Systems Reliability. This service assesses whether an entity's internal information systems (financial and nonfinancial) provide reliable information for operating and financial decisions.

PPC’s Guide to Nontraditional Engagements describes each of the 13 services. The publication can be ordered online at ppc.thomsonreuters.com or by calling (800) 431-9025.

105.6 The now defunct committee had no standard-setting authority and separate assurance services standards were not issued. However, the AICPA issued some nonauthoritative guidance regarding performing
certain of these engagements. In general, if a service involves financial statements, practitioners should refer to SASs or SSARS. If it involves a written report on the reliability of another party's written assertion, practitioners should look to SSAEs. When a service is not covered by any of those standards, many practitioners follow the consulting standards. While that approach is not necessarily required for services that do not fall under the consulting standards, the authors believe it is harmless since the consulting standards essentially reiterate Rule 201 of the *Code of Professional Conduct*, which all practitioners are required to follow.

**Evaluate Firm Capabilities**

105.7 After deciding what services to offer, the firm should assess its ability to provide those services. If the firm already serves the needs of small businesses and individuals, it will probably find that it has the ability to provide the services needed by health care professionals. However, because of the unique aspects of serving these clients, the firm may need to develop or obtain additional expertise. Existing partner and staff skills and availability should be assessed, and additional training should be provided as necessary. This *Guide* provides an excellent source for such training.

105.8 A critical element in the evaluation of the firm's capabilities is an assessment of the firm's philosophy about services to health care professionals. This philosophy bears directly on the extent of the firm's commitment to this area of practice. It will affect whether the practice will be a growth-oriented area or an area that will simply leverage existing staff. This, in turn, will affect decisions regarding personnel, training, organization, and marketing.

105.9 **Obtaining Expertise**

In addition to this *Guide*, **PPC's Guide to Health Care Consulting** provides a wealth of information about the health care industry and consulting services that practitioners provide to the various types of health care providers. Practitioners might also consider joining one or more of the organizations listed in Exhibit 1-2 to obtain health care industry information and training seminars. Additionally, Appendix 9P provides a list of health care information sources available on the Internet.

**Exhibit 1-2**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Internet Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Medical Group Association</td>
<td><a href="http://www.amga.org">www.amga.org</a></td>
</tr>
<tr>
<td>American Medical Association</td>
<td><a href="http://www.ama-assn.org">www.ama-assn.org</a></td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td><a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a></td>
</tr>
<tr>
<td>Department of Health and Human Services</td>
<td><a href="http://www.dhhs.gov">www.dhhs.gov</a></td>
</tr>
</tbody>
</table>
Analyze the Competition

105.10 An understanding of the nature and extent of the competition is a significant factor in the development of a marketing plan. Questions to be investigated include:

a. What services are other firms providing to health care professionals?

b. Who are they servicing?

c. What rates are being charged?

d. Are there needs that are not being met?

105.11 The existence of competing firms offering services should not necessarily be considered an impediment to entering the market. In some cases, just the opposite may be true. The existence of competing firms may indicate a need for such services. The key is to determine what services are being offered. The firm can then determine if it can offer those same services more effectively, if it can offer services that are not currently being offered, or both.

Identify the Target Market

105.12 The target market should be defined in some detail. A marketing strategy depends on a clear understanding and explicit identification of the target market. Once the firm has decided to provide services to health care professionals, it has, to some extent, already defined its target market. However, defining the target market more precisely is a good method for developing a niche that can later be expanded. For example, the firm may decide to target new medical school graduates or young physicians who are attempting to start their
own practices. This is one way to develop a practice without having to approach established physicians that are already locked-in to another firm.

105.13 Another alternative is to target a specific specialty. Because, as discussed in section 101, there are many types of health care professionals, targeting a specific profession is another way to establish a practice. The strong referral network within these specialties also provides an excellent opportunity for practice expansion.

**Develop a Marketing Strategy**

105.14 A marketing strategy is a broad plan that forms the basis for selecting specific marketing methods. It should be tailored to a specific service definition and a specific market definition. It should also include goals that are expressed in measurable terms, for example, the number of new clients or amount of new billings within a specified time period. This gives the firm a yardstick by which to measure results. When possible, the statement should contain approaches to market differentiation. This enables the firm to distinguish itself from competitors. As a general rule, the more specialized the service, the easier it is to differentiate. Differentiation plays an important role in attracting new clients who, in turn, become targets for the firm's other services.

**Select Specific Marketing Methods**

105.15 Marketing methods are specific techniques for initiating discussion with a prospective client about a potential engagement. The methods used should be consistent with the marketing strategy, the market definition, and the services the firm plans to offer. Methods should be evaluated in light of the firm's ability to use them properly, their appropriateness for the target market, and the cost/benefit associated with them. The authors' experience indicates that reliance should not be placed on any one method. A combination of techniques is the most effective way to reach the targeted market. Also, a firm should use the methods with which it is most comfortable. The availability of a wide variety of marketing techniques enables the firm to choose those that are consistent with the firm's professional image. Some of the more effective marketing methods for obtaining health care clients are discussed in the following paragraphs.

105.16 **Personal Sales Calls**

This is the most direct way to initiate an engagement. A list of prospective clients who meet the firm's market definition should be developed. The appropriate partner should then schedule a meeting with each prospect to discuss the services the firm can provide. These meetings should then be followed with a phone call or letter. Personal sales calls are commonly used to follow up on referrals (discussed in paragraph 105.20).

105.17 **Direct Mail**

A direct mail piece can consist of a personal letter and business reply card or a professionally designed brochure. The most effective use of either is to qualify clients through the use of postage-paid reply cards that indicate interest in particular services. A word of caution—CPA firms should exercise care in their direct marketing communications to ensure that the communications emphasize only the services the firm has available and do not include superlatives. In drafting marketing communications, firms should consider the
impact of the language in the context of legal liability risk since many plaintiffs' attorneys are now using such communications to try to hold CPAs to a higher standard than that required in the professional literature.

105.18 **Newsletters**

Newsletters can serve as an excellent vehicle for marketing the firm's consulting and other services. They are an effective means of putting forth the firm's name to clients on a regular and continuous basis.

105.19 Newsletters can be developed internally or can be purchased from outside sources. A firm that prepares newsletters in-house often finds that the cost of professional time spent in designing, writing, and editing the publication is substantial. Also, there is the continuing problem of having enough publishable articles on hand to fill the pages. For those reasons, smaller firms generally find it easier to purchase a newsletter from outside sources. (Such sources include Thomson Reuters, publisher of *Tax and Business Alert*; the AICPA, publisher of *CPA Client Bulletin*; and PDI Global, Inc., publisher of a variety of newsletters). With a purchased publication, the product is delivered to the firm ready to be mailed to the client. Larger firms may prefer developing their newsletters in-house. Those firms have greater control over the editorial content of the newsletters, tailoring the contents of the publications more directly to the interests of their clients. Using word processing software and laser printers, most firms can produce professional-looking client newsletters.

105.20 **Referrals**

Other professionals familiar with the firm's services and not in competition for providing those services are valuable sources of new engagements. Attorneys and bankers are traditionally the best sources of referral business. Also, as noted in paragraph 105.13, the strong referral network within health care specialties also provides an excellent opportunity of practice expansion.

105.21 **Firm Seminars**

Presentations of firm services to small groups of clients and prospective clients are also a good marketing technique. Each seminar should have no more than 30 participants (15-20 is preferred) for optimal results. The seminar should ordinarily cover financial and/or tax topics that are of interest to the target market, either personally or professionally.

105.22 **Joint Seminars**

Joint seminars, like firm seminars, are presentations on firm services to small groups of clients and prospective clients. They are ordinarily presented in cooperation with other professionals, such as bankers and attorneys, and cover a wide variety of topics that are of interest. Such seminars may also be presented in cooperation with professional organizations and local professional societies of health care professionals.

105.23 **Writing Articles**

Articles in health care trade and professional journals help to establish the credentials of the firm and its partners. They increase awareness of the firm and can be a direct source of new engagements.

105.24 **Speaking Engagements**
Delivering speeches, similar to writing articles, leverages the practitioner's time by putting the speaker in front of a large number of prospective clients. Opportunities to deliver talks on services the firm provides abound because many groups are generally eager for such presentations. Like joint seminars, speaking engagements are most effective when delivered to professional organizations and local professional societies to which health care professionals belong.

105.25 **Advertising**

A wide variety of media is available to promote the expertise and services provided by the firm. Such advertising is most effective when placed in trade and professional journals. A *word of warning*—many firms consider advertising “too commercial.” If poorly done, it can lower the professional image of the firm.

105.26 **Surveys**

In conducting a survey, a firm asks questions on important topics and publishes a summary of the answers. For example, CPA firms with experience in compensation consulting may conduct a wage and salary survey. The results of the surveys may then be published and many entities may use the results to administer their compensation programs. Survey participants are made aware of your firm's interest in, and knowledge of, the subject being surveyed. Also, local newspapers and trade publications will readily publicize survey results, thus enhancing the public visibility of the firm. (Be sure to inform participants that the survey results will be publicized.)

105.27 There are several disadvantages to conducting surveys. First, surveys do not often produce immediate benefits for the CPA firm. Second, a firm will usually incur a great deal of time and expense in designing a survey and processing the responses. Finally, mailed surveys must be monitored to make sure that a reasonable sample is obtained. (In wage and salary surveys, for example, lower-paying entities are more likely to participate in mailed surveys than higher-paying entities; additional mailings or phone calls to higher-paying companies are sometimes required to ensure a representative sample.)

105.28 **Marketing and Niche Association**

PDI Global, Inc. provides products, marketing and management programs, niche-specific associations, and educational programs to CPA firms across the country. One of the services it provides is to help member firms develop customized marketing plans and programs supported by high-quality materials and services. PDI Global, Inc. also manages several niche marketing and networking associations. In addition, the National CPA Health Care Advisors Association (HCAA) is a nationwide network of CPA firms that serve the health care industry. For additional information, contact PDI Global, Inc. ([www.pdiglobal.com](http://www.pdiglobal.com)), or the HCAA ([www.hcaa.com](http://www.hcaa.com)).

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2 It is important that direct mail appear “safe” to open. Always use the firm's preprinted envelopes and, if possible, use a higher postage rate than bulk rate for the mailing. In any event, never use hand addressed envelopes for direct mail.
106 Characteristics of a Successful Practice

106.1 Obviously, a successful practice is one that is profitable. There are certain characteristics, however, that successful firms exhibit and that set them apart from others that provide services to health care professionals. Some of those characteristics are discussed in the following paragraphs.

Commitment

106.2 To be successful, a firm must commit sufficient financial, personnel, and physical resources to its health care practice. The nature and extent of the resources necessary depends primarily on the firm's service and market definitions. However, within the framework of those definitions, a realistic assessment must be made of the total investment in time and cost that will be necessary. Unless the firm is willing to make that commitment, its health care practice may not be successful.

Leadership

106.3 Effective leadership is an essential ingredient for success. The authors recommend that a single partner be put in charge of starting and developing the health care practice. Committees are usually inefficient, and the assignment of less senior personnel may be viewed as a lack of serious commitment on the part of the firm.

106.4 One exception to placing a partner in charge of the health care practice is to select an experienced staff member who would be a partner if the firm's volume were sufficient. This person will strive for successful practice development if he or she perceives the opportunity as a ticket to partnership.

Philosophy

106.5 As discussed in paragraph 105.8, a critical element in the evaluation of the firm's capabilities is an assessment of the firm's philosophy about services to health care professionals. This philosophy bears directly on the extent of the firm's commitment to this new area of practice. Elements of philosophy that coincide with a successful practice include a marketing orientation, adaptability, and a cooperative attitude among partners.
106.6 Some firms treat health care professionals as simply another client and do not emphasize that these clients are unique. When this happens, the extent of services rendered is likely to be less than the full range of services that health care professionals often demand.

Specialization

106.7 To achieve a successful health care consulting practice, a firm must have the specialized expertise needed to provide a wide variety of services. Sufficient personnel and resources must be committed to achieve this expertise. Consequently, at least one person within the firm should be designated as the firm's specialist in the health care area and should be charged with the responsibility of developing the necessary expertise. This will ordinarily be the person in charge of developing the practice.

Reputation

106.8 To be successful, the firm must have the reputation within the health care community of being able to effectively meet the needs of its clients. Once developed, the firm's reputation can be its greatest asset in obtaining new clients. Achieving such a reputation requires strong marketing techniques, as discussed in section 105, and the ability to continually provide the needed services.
107 How This Guide Helps

107.1 This Guide provides both the technical guidance and practical advice needed to successfully serve health care clients. It integrates the practical advice and technical requirements for providing services into a complete set of practice aids that can be copied and used immediately in the practice. These practice aids include work programs, correspondence examples, checklists, and financial statements—all tailored to the special requirements of health care professionals. Those practice aids also interface with the PPC quality control system and help a firm meet the AICPA’s quality control standards. The guidance and practice aids in this Guide are also excellent tools for training the staff who will work on health care engagements.

107.2 Extensive guidance and practical advice on each of the various services commonly needed by health care clients is also provided. In providing this information, this Guide draws on the proven excellence of many of PPC’s other guides on accounting, consulting, financial planning, practice management, and tax matters. However, this Guide focuses primarily on those considerations that are unique to health care professionals.