Defending the solo and small practice neurologist

Elaine C. Jones, MD

David A. Evans, MBA

Summary

Changes in health care are having a dramatic effect on the practice of medicine. In 2005, a National Center for Health Statistics survey showed that 55%–70% of physicians are in small/solo practices. These data also demonstrated that 70% of physicians identified themselves as owners. Since passage of the Affordable Care Act (ACA) in 2010, neurologists report an 8% increase in academic practice settings, a 2% decrease in private practice settings, and a 5% decrease in solo practice settings. Surveys of family physicians showed that 60% are now employees of hospitals or larger groups. A survey by The Physicians Foundation showed that 89% of physicians believed that the traditional model of independent private practice is either “on shaky ground” or “a dinosaur soon to go extinct.” With the changes expected from the ACA, solo/small practices will continue to face challenges and therefore must pay close attention to business and clinical metrics.

While trends in health care suggest that physicians are leaving small practices to join larger groups or hospitals, many want to remain in what they know and like.^{1,2} With the changes expected from health care reform, smaller practices face new challenges. By regularly examining your business model/metrics, office efficiency, and revenue streams there are ways to maintain a viable small practice. It is important to understand what is meant by a “small practice,” as there are legal and financial implications. The federal government and the Internal Revenue Service follow the Small Business Association or North American Industry Classification System definitions. These require businesses to be privately owned and, in the case of medical practices, to have annual revenue of less than \$10 million.³ The Affordable Care Act (ACA) and insurance industry define small business as less than 100 employees. Provisions of the ACA vary whether the business is less than 25 employees, less than 50 employees, or less than 100 employees. Many states define small businesses as less than 50 employees and apply this definition to tax calculations and health care reform measures.⁴ There are legal definitions based on corporate structure (table 1), and these will influence legal risk, tax requirements, and reporting requirements.⁵ It is important to discuss these models with a lawyer and accountant to understand which option is best.

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Correspondence to: ejones@chartercare.org

Table 1 Legal structures for businesses

Type	Filing requirements	Legal protections	Ownership
Corporation	+++	+++	Shareholders
Limited liability company (LLC)	++	++	1 + members
Partnership	+	+	1 + partners
Sole proprietor	+	+	Individual

Abbreviations: + = least work/protections; +++ = most work/protections.

To sell or not to sell?

A survey of hospital administrators in Georgia showed that 70% of recent hospital acquisitions occurred because physicians approached them wanting to sell.^{6,7} If a physician is in a small/solo practice, there are other options besides full employment. Physicians and hospitals use alignment models as an interim step, and these fall into 3 basic types: limited, moderate, and full. In a limited alignment model, a physician is hired as a medical director to oversee specific clinical lines within the institution, such as the stroke center, or is contracted to do teaching/coverage services. This model provides needed services to the institution while giving the provider additional revenue streams for his or her private practice. In a moderate alignment model, a physician and hospital collaborate on services with gain-sharing possibilities, as with an accountable care organization.⁸ Or a small practice might hire the hospital for management services, such as information technology support or human resources. In these situations the practice outsources administrative functions for a fee that is less than if they had to employ someone themselves. Lastly, in a full alignment model, more control is shifted to the hospital.⁸ An example of this would be a medical service organization model in which the practice is still an independent legal entity but receives payments for work from the hospital. This allows for a strategic partnership but maintains some control in the practice. Ultimately, control can revert back to the hospital in times of disagreement. This full alignment model can be a stepping stone toward full employment. Another form of alignment is through an independent physician association (IPA). These are not only with hospitals and are most often primary care-focused; however, some specialty-specific IPAs are developing. These allow for sharing of administrative functions while maintaining an independent practice. When deciding whether to sell or to pursue alignment, it is important to know your ultimate goal. If the goal is to have less administrative responsibility and focus on clinical work, then perhaps it is best to sell and become an employee. For those that like making decisions about the practice, perhaps outsourcing administrative responsibilities while keeping control is the better model. Table 2 summarizes many of the options available. Since the biggest driver for selling or aligning is the financial viability of the practice, it is vital to monitor this closely.

Table 2 Summary options for solo/small practices

Greater autonomy	Greater support	Optional revenue streams
Limited alignments	Full alignment	Clinical research
Medical directorships	Medical service organization	Property purchase/rental options
Teaching/coverage contracting		Incentive programs
Independent physician association		Legal/expert consulting services

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Quantitative analysis of the business

In any business, it is imperative to regularly assess for optimal operation (e.g., financial, productivity-related [staff and providers], technological). Financial monitoring is achieved by routinely reviewing key practice metrics that most practice management systems can generate automatically on a set schedule. In order to arrive at the core driver of negative effects, it may be necessary to run reports by payer, service type, or even provider. All reports should be net of any credits such that all credit balances are excluded in order to ensure accuracy. The practice should establish benchmarks for each report and compare them to generally accepted best practice measures (www.mgma.com). At a minimum, a practice should schedule a review of the following reports at set times weekly or monthly, as appropriate.

Days in accounts receivable

This metric allows a practice to assess the average length of time it takes to be paid by all parties after services are performed. Each practice's days in accounts receivable (A/R) will vary based on the services performed, the percentage of clean claims processed at first pass, the number of appeals/denials, and the effectiveness of the staff and systems in place. Each practice should establish a baseline analysis for the practice followed by the same metric by payer. Any variances should be further analyzed to determine payer-based deficiencies. Another analysis would be to evaluate variances in days in A/R by type of service (i.e., procedural vs evaluation/management). Each of these will allow for a more focused approach to identifying areas for improvement.

Percentage of accounts receivable 120+ days

This report is standard in most practice management systems and will generally include the percentage of A/R in buckets (0–30 days, 31–60, 61–90, 91–120, 121+; or 121–150, 151+). The buckets allow a practice to monitor the total A/R by its aging. Of these buckets, the one to monitor most frequently is the >120 days. Practices should verify that this report is net of credits and that the report is based on date of service. Many practice management systems calculate this report from the date the claim was created and may re-age if a resubmission of claim has occurred. Although this seems practical, it may mask issues with delays in claim submission, denials, timely responses to payers' requests for additional information, and other deficiencies in claims management. It is recommended that all accounts >120 days be reviewed by someone not involved in the claims process. The reviewer should analyze the account from start to finish, identifying process or staff deficiencies that may require correction.

Denial rate

The denial rate measures the percentage of claims that were denied once they were submitted for payment. It is preferable to have this number at or below 5% of the total claims submitted, with anything over 10% worrisome. This report is not standard in all practice management systems but is available through the claims clearinghouse or can be calculated manually. This rate should exclude internal denials caught by the practice's software or by manual edits prior to electronic claims submission, even though these are important in order to implement practice improvements and identify input deficiencies. It is advisable to access real-time denial reports with detail including remark codes by payers. This allows the practice to identify trends and address them in a timely manner. If the practice cannot obtain an expanded

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report, then a randomized spot check of denied claims should be performed routinely by someone not involved in the claims process.

Adjusted collections percentage and adjustments by category

The adjusted collections percentage measures the effectiveness of the practice in capturing all eligible reimbursement. Practice management systems often have a limited ability to produce this report, as they may not allow the practice to correlate payments to each service. Many systems only have the ability to capture the net collections for the report period with no correlation to the service date. This can result in an inability to accurately monitor trends. In that case, it is imperative for the net collections report to be viewed in tandem with the practice's adjustment report in order to identify inappropriate patterns in adjustments or denials. Although an adjustment report is standard in most practice management systems, the practice should have the ability to add or revise adjustment categories in order to produce a useful report. The practice management system should allow for adjustments to be defined as "collectable" or "noncollectable." Collectable is an adjustment type that should have been collectable from a payer, patient, or other responsible party but was nevertheless not paid, e.g., past claims-filing deadline, past appeals-response deadline, authorization not obtained, bad debt/collections. Noncollectable is any adjustment that the practice was not expecting to receive, e.g., contractual adjustment, sequestration.

Efficiency measures

Finally, monitoring office efficiency is important to the financial success of the business. For example, rather than hiring another physician, perhaps an advanced practice provider (APP), such as a nurse practitioner or physician assistant, will do. APPs can increase revenue and also improve efficiencies. Some staff may be able to perform dual functions, such as a licensed practical nurse who can do medication refills and also act as an office manager.

Other revenue streams

As health care dollars shrink, other sources of revenue should be considered. Some have turned to participating in research trials for added income. This needs to be carefully monitored in order to ensure income covers any added overhead expenses, such as staff time, storage of supplies/records, and reporting requirements. Another option is property ownership as opposed to renting space. Long-term investment in property can be a good way to build equity in the business, so purchasing may make sense for the solo/small practice. Commercial realtors in a region can be good advisors for this type of investment. There may be more upfront costs and perhaps increased overhead, but this is invested and is building equity. Another benefit to property ownership is establishing community relationships. Being a small business owner and participating in a local chamber of commerce can create goodwill and even build referrals.

Incentive programs (and penalties)

The ACA and private insurers are implementing payment incentives and penalties to move practices to new models. One such program is the electronic medical record (EMR) "Meaningful Use" incentive program started by the Centers for Medicare & Medicaid Services in 2011. By participating in this program from the beginning, practices could receive a maximum incentive of \$44,000. The incentives decrease through 2014, and penalties for not participating begin in 2015 (table 3).⁹ The incentive programs are meant to help offset some

Table 3 Medicare EMR “Meaningful Use” incentive program

Year to start	Maximum incentive	Consecutive years	Penalty on CMS reimbursements
2011	\$44,000	5	0
2012	\$44,000	5	0
2013	\$39,000	4	0
2014	\$24,000	3	0
2015	0	0	–1%
2016	0	0	–2%
2017	0	0	–3%
2018	0	0	Up to –5%

Abbreviations: CMS = Centers for Medicare & Medicaid Services; EMR = electronic medical record.

of the costs of EMR startup. The American Academy of Neurology (AAN) has partnered with American EHR to provide information to practices not already involved with an EMR (<http://www.aan.com/practice/electronic-health-records-vendor-information>). Another source for free EMR information is Klas Research (www.klasresearch.com), although an extensive survey has to be submitted for access.

Other incentive programs that do not require a full EMR system include the Physician Quality Reporting System (PQRS), group practice reporting option, and Electronic Prescribing (eRX). Stand-alone electronic prescribing systems meet eRX requirements for practices, and the AAN has partnered with CECity to provide a registry option for practices to report PQRS measures (<https://aan.pqriwizard.com/default.aspx>).

The AAN is working with other organizations to get government and private insurers to align all incentive programs in order to limit duplicate reporting requirements. Another trend among insurers is to focus on tiering physicians or practices. It is important to understand how these tiers are established because they affect reimbursement and referrals. Most of these programs are currently based on cost profiling, but there are attempts to include quality data in the assessments. Providers in small/solo practices need to monitor these programs and challenge them if they feel they are being inappropriately rated. As new payment models evolve, referring practices are being incentivized for less costly care. They may use tiered lists to select which specialists to use for referrals. While it is important to educate referring providers, patients, and insurers that less costly care is not necessarily better care, neurologists can also help by limiting overutilization. If practices are following evidence-based guidelines such as Choosing Wisely (<http://www.choosingwisely.org>) or only performing testing that will change management, then costs can be supported.

Finally, participating in incentive programs means a practice agrees to be audited for accurate reporting. These auditing companies are called recovery audit contractors (RACs) and are attempts by insurers to evaluate overpayments (or underpayments). These companies have certain limitations. For example, they are only allowed to look back 3 years and the number of records they can request is limited based on the size of the practice. In a 2012 survey by the AAN, 18.3% of neurologists reported being audited in the past 12 months. While appeal of these audits can be expensive, it may be worthwhile. In 2011, 70% of RAC appeals resulted in reversals.¹⁰ When a practice performs regular internal auditing of its own records, it will be better prepared for external audits, which could limit errors and damages.

How technology can help

Technology can help to simplify work, improve quality of care and lead to bonus payments, and reduce staffing needs. EMR systems can perform checks for conflicts between medications

and allergies. This can prevent iatrogenic errors in prescribing. These systems can also notify providers when follow-up testing needs to be performed. If a patient needs labs done every 6 months, this can be programmed in and the EMR will inform the practice when due. If a patient does not go for a test, the system can advise the practice to follow up. More systems are being programmed with insurance formulary information so physicians can tell which medicines are covered. Instead of prescribing a medicine and getting a call the next day from the pharmacy saying it isn't covered or is too expensive, providers can know as soon as they write the order. Technology can help practices collect money at the point of service by letting staff see whether a patient has an outstanding balance, deductibles, copays, etc. Portable credit card payment systems such as Square or Quicken can allow swiping of credit cards on a smartphone or tablet device for immediate collection. The portability of these devices is good for practices with satellite offices and they are often less costly than traditional credit card processing systems. As the business becomes more automated, there may be less need for staff to do billing and coding. This may allow for reduced overhead for a smaller practice.

What the future holds

While health care reform seems to be pushing toward consolidation of services into larger systems, this does not have to mean the end of small or solo practices. Things will be more challenging in the future and close attention will have to be paid to revenue, profit margins, legal issues, and reporting requirements. Practices will have to be flexible and monitor services more closely. Some practitioners may decide it is no longer worth the work or risk required. However, for those who enjoy running their own small business and want to continue, it cannot be business as usual but it does not have to go the way of the dinosaur either.

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