The Road Ahead

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With the July 2012 issue of Clinical Gastroenterology and Hepatology, the responsibility for the “Practice Management” special section changed, in conjunction with overall editorial responsibility, to a new group led by Hashem El-Serag, MD, MPH. Joel Brill, MD, AGAF, whose knowledge is unparalleled in our specialty about health care reform, reimbursement, and practice management, has edited this section with admirable care since its inception. Having assumed the role of special section editor, I will bring experience from 10 years in academic gastroenterology, 20 years in private community practice, a first-hand perspective of current gastroenterology practice business models, and extensive experience in quality improvement and development of both performance measures and the Digestive Health Outcome Registry.

For this initial article in the renamed section now called “Practice Management: The Road Ahead,” I have outlined 5 overarching concepts that will likely alter our practices in the coming decade (The Road Ahead). Next, I will discuss a new, coordinated and proactive initiative of the American Gastroenterological Association (AGA) designed to help gastroenterologists in both community and academic practices meet the considerable challenges created by these concepts (Roadmap to the Future of GI Practice) and finish with a brief outline of articles to come (Practice Management: The Road Ahead).

The Road Ahead

The future of gastroenterology is spelled “PPACA.” Actually, I am not referring to the Patient Protection and Affordable Care Act signed into law on March 23, 2010, by President Barack Obama. This is the health care act that has generated so much controversy and whose central tenet, compulsory financial participation in health insurance (also known as the individual mandate), is under constitutional review by the Supreme Court of the United States. A decision likely will be known by the time this article is published.

The PPACA that I will discuss refers to 5 concepts that are the foundation for current health care reform—all of which have bipartisan political support and are currently being implemented by both federal and commercial payers. Ramifications emanating from these 5 concepts will determine how we practice gastroenterology in the coming decade and what infrastructure will be needed to support our practices. This will hold true for large integrated delivery networks (IDN) including academic medical centers (AMC) and for practices that wish to remain physician-owned and independent of health system employment. Established IDNs may be in the best position to accomplish the health care imperatives of these 5 concepts because of their integrated business model (Figure 1). The major issue for independent gastroenterology groups will be whether they can successfully coexist with (and support) the overarching health care mandates for care integration for which IDNs are suited and equal the health outcomes and resource efficiencies of established IDNs. If they cannot or if they are unable to integrate their health information systems with regional hospital systems, then they likely will be left with little choice but to enter into employment within an IDN. Five concepts that will be both our greatest challenge and greatest opportunity are as follows:

- Performance measures
- Population management
- Aggregation
- Cost
- Accountability

In some form or another, all of these concepts are contained within the health care reform law. They support a nationally agreed-upon agenda to enhance value by improving health of both individual patients and larger patient populations while reducing cost.1,2 This triad has been termed the “Triple Aim.”3

Performance Measurement

Over the last decade, virtually all stakeholders have agreed that strategies to improve health care value must include public reporting of clinical outcome measures and linking such measures to reimbursement.4 Hence, enormous efforts have

Abbreviations used in this paper: AASLD, American Association for the Study of Liver Disease; ACG, American College of Gastroenterology; ACO, accountable care organization; AGA, American Gastroenterological Association; AMC, academic medical center; ASGE, American Society for Gastrointestinal Endoscopy; CCFA, Crohn’s and Colitis Foundation of America; CMS, Centers for Medicare and Medicaid; EMR, electronic medical record; GI, gastroenterology; IDN, integrated delivery networks; NPMS, National Performance Measure Set; NQF, National Quality Forum.

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Resources for Practical Application

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been expended to develop valid clinical metrics to improve internal operations, develop process efficiencies, and report results externally. Thanks in part to the foresight of Martin Brotman, MD, AGAF, AGA, President in 2002, the AGA got ahead of the quality trend and began creating guidelines and measures to support quality efforts. Words written by Dr Brotman 7 years ago still ring true today: “The entire American health care delivery system (physicians and hospitals) must be motivated to lead the new approach to defining and improving quality rather than becoming passive recipients of mandates based on unpredictable objectivity.”

Until passage of the 2010 health reform law, the quality agenda in the United States was uncoordinated and confusing for providers, health systems, payers, purchasers, and patients. The new law addresses this confusion directly by calling for pertinent stakeholders to join together under a single national strategy. This effort now is coordinated by the National Priorities Partnership, an initiative overseen by the National Quality Forum (NQF), an entity that works under contract to the Centers for Medicare and Medicaid (CMS).

In 2011, NQF, in conjunction with the Department of Health and Human Services, created the first National Quality Strategy that shaped infrastructure to build a National Performance Measure Set (NPMS). The NQF 2012 Report to Congress states that the measure set will be a parsimonious collection of rigorously validated metrics that relate to health outcomes, patient experience, or resource use. Eighty-five percent of measures now used in public and commercial reimbursement programs have been endorsed by NQF and are contained in the NPMS; most others are pending review and endorsement.

Process and outcome measures differ in their focus and intent. Process measures now are used primarily for internal quality improvement. Most measures related to “quality” of endoscopy are in fact process and not outcome measures, including adequacy of colonic preparation prior to exam, completeness of procedural documentation, or whether the colonoscopy included an examination of all areas of the colon. When the AGA, American Society for Gastrointestinal Endoscopy (ASGE), and American College of Gastroenterology (ACG) together recommended to NQF a composite measure concerning complete colonoscopy documentation, it was rejected because it did not correlate closely to a patient health outcome.

As described by Dorn, the National Committee for Quality Assurance has been responsible for measures aimed at hospitals, health systems, and insurance companies and has created the Healthcare Effectiveness Data and Information Set Measures aimed at individual providers or provider groups, typically developed by the AMA-sponsored Physician Consortium for Performance Improvement, an entity that includes over 100 medical organizations, including AGA, ASGE, and ACG. Once measures are developed, they go through an evaluation, public comment, and endorsement process directed by NQF that typically requires about 18–24 months from point of inception to endorsement. Once endorsed, measures can be used in government or commercial incentive programs including the CMS Physician Quality Reporting System. Within this broad set of measures are a group of measures directly related to the practice of gastroenterology. Since 2006, the AGA has provided substantial staff and volunteer physician support in leading the effort to develop a gastroenterology-specific set of measures to include in the NPMS (GI-NPMS). Payers have indicated their need for endorsed measures that relate to both procedural and cognitive aspects of gastroenterology for use in value-based reimbursement. Current measures in the GI-NPMS are listed in Table 1. The development of GI-NPMS has been a result of close cooperation among the AGA, ASGE, ACG, American Association for the Study of Liver Disease (AASLD), plus the Crohn’s and Colitis Foundation of America (CCFA) for measures related to inflammatory bowel disease. As a result of this cooperative effort, we have avoided creation of duplicative or competitive accountability measures for our specialty.

Within a few years, Physician Quality Reporting System measures and those used in commercial payer incentive programs will be consolidated into the NPMS and will form the basis from which measures specific for specialists or primary care will be derived and used for value-based payments from the federal level to regional accountable care organizations (ACO). Persistent attention to this evolving infrastructure by our societies has been important to assure development of measures that are fair, reasonable, and important to gastroenterologists and their patients.

**Population Management**

The coming decade in health care will be characterized by intense cost pressure and a demand for clinical coordination, especially for patients with complex or chronic diseases. This has given rise to ideas to build ACOs, patient-centered medical homes and medical neighborhoods where specialists assume principle care for patients with chronic illnesses related to their practices. Gastroenterologists, who traditionally served as consultants to patients as individuals, may be confronted by a request to demonstrate success at improving the health of a population of like patients. The emergence of large IDNs willing to assume responsibility for population-based clinical outcomes or willing to contract for “total cost of care” has set a high bar for other health care systems to meet. As large employers begin to steer their patients toward high-performing IDNs, independent GI groups will be challenged to develop business infrastructure to demonstrate similar results.
Examples of how gastroenterology practices begin creating a population-based focus of care have been published. These examples provide us with an opportunity to lead development of clinical service lines important to our practices such as colon cancer prevention, comprehensive management of patients with inflammatory bowel disease, and treatment of chronic liver disease to name a few examples. Such a focus will require creation of new clinical decision support tools embedded in our electronic medical records (EMRs) that will help standardize care, track resource use, alert us to needed preventive or monitoring services, and to educate patients about risks and benefits of various options of care.

**Aggregation**

The dramatic consolidation that has occurred over that last 10 years within health benefit companies, hospital systems, physician groups, and purchasing cooperatives has been lost on no one who is involved in health care. Community gastroenterology practices have been dominated for a generation by a small practice model where 1–5 physicians work together and often have part or full ownership in an ambulatory endoscopy center. The increasing regulatory burden, demand for sophisticated information management integrated with regional IDNs, and decreasing procedural reimbursement all have contributed to a diminishing financial margin for small practices. Reduction in year-end income and the need for sophisticated practice management have resulted in many small practices following 3 business strategies: 1) merge with other physicians to form larger physician-owned practices, 2) sell their practices to IDNs, or 3) retire and dissolve. The number of medical practices owned by hospital systems continues to increase while the creation of new physician-owned practices has been dramatically reduced as newly graduated gastroenterology (GI) fellows

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**Table 1. Gastroenterology National Performance Measure Set**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>PQRS number</th>
<th>NQF number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CRC screening</strong></td>
<td>Rate of population is screened for CRC</td>
<td>113</td>
<td>0034</td>
</tr>
<tr>
<td><strong>Colonoscopy performance</strong></td>
<td>Surveillance interval—past polyp</td>
<td>185</td>
<td>0659</td>
</tr>
<tr>
<td></td>
<td>Surveillance after a normal exam</td>
<td>Not in PQRS</td>
<td>0658</td>
</tr>
<tr>
<td></td>
<td>Colonoscopy after colon cancer treatment</td>
<td>Not in PQRS</td>
<td>0572</td>
</tr>
<tr>
<td></td>
<td>Adenoma detection rate</td>
<td>In development</td>
<td>In development</td>
</tr>
<tr>
<td><strong>Inflammatory bowel disease</strong></td>
<td>Documentation of type, location, activity</td>
<td>269</td>
<td>Pending</td>
</tr>
<tr>
<td></td>
<td>Use of corticosteroid sparing therapy</td>
<td>270</td>
<td>Pending</td>
</tr>
<tr>
<td></td>
<td>Bone loss assessment</td>
<td>271</td>
<td>Pending</td>
</tr>
<tr>
<td></td>
<td>Influenza immunization</td>
<td>272</td>
<td>Pending</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal immunization</td>
<td>273</td>
<td>Pending</td>
</tr>
<tr>
<td></td>
<td>TB testing prior to anti-TNF therapy</td>
<td>274</td>
<td>Pending</td>
</tr>
<tr>
<td></td>
<td>Assessment of hepatitis B prior to anti-TNF</td>
<td>275</td>
<td>Pending</td>
</tr>
<tr>
<td><strong>Hepatitis C (chronic)</strong></td>
<td>Confirmation of viremia</td>
<td>83</td>
<td>0393</td>
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<tr>
<td></td>
<td>RNA testing prior to therapy</td>
<td>84</td>
<td>0395</td>
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<tr>
<td></td>
<td>HCV genotyping</td>
<td>85</td>
<td>0396</td>
</tr>
<tr>
<td></td>
<td>Antiviral therapy prescribed</td>
<td>86</td>
<td>0397</td>
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<td></td>
<td>HCV RNA testing at week 12</td>
<td>87</td>
<td>0398</td>
</tr>
<tr>
<td></td>
<td>Counseling about alcohol use</td>
<td>89</td>
<td>0401</td>
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<tr>
<td></td>
<td>Counseling about contraception use</td>
<td>90</td>
<td>0394</td>
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<tr>
<td></td>
<td>Hepatitis A vaccine in patients with HCV</td>
<td>183</td>
<td>0399</td>
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<tr>
<td></td>
<td>Hepatitis B vaccine in patients with HCV</td>
<td>184</td>
<td>0400</td>
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<tr>
<td><strong>Preventive care</strong></td>
<td>BMI screening and follow-up plan</td>
<td>128</td>
<td>0421</td>
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<tr>
<td></td>
<td>Screen for depression and follow-up plan</td>
<td>134</td>
<td>0418</td>
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<td></td>
<td>Screen for tobacco use and intervention plan</td>
<td>226</td>
<td>0028</td>
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<td><strong>Gastroesophageal reflux</strong></td>
<td>Upper GI study in adult patients with alarm symptoms</td>
<td>Not in PQRS</td>
<td>0622</td>
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<tr>
<td><strong>Other possible measures</strong></td>
<td>Documentation of medications</td>
<td>130</td>
<td>0419</td>
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<td></td>
<td>Exposure time documentation for fluoroscopy</td>
<td>145</td>
<td>0510</td>
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<td></td>
<td>Screening for unhealthy alcohol use</td>
<td>173</td>
<td>Not in NQF set</td>
</tr>
</tbody>
</table>

**NOTE.** Current (2012) endorsed performance measures, which are applicable to a gastroenterology practice. These measures make up the Gastroenterology National Performance Measure Set. Measures that are endorsed by NQF can be used in incentive programs created by commercial health benefit companies. Some measures can be reported individually and some as a set through a qualified registry such as the Digestive Health Outcome Registry of the American Gastroenterological Association. If a measure has a number under PQRS or NQF, it implies that measures are endorsed (NQF) and are in use for incentive funds (2012 PQRS). Some measures are pending NQF endorsement. Data from: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html. Accessed May 2, 2012. BMI, body mass index; CRC, colorectal cancer; HCV, hepatitis C virus; NA, not applicable (not endorsed by NQF); PQRS, Physician Quality Reporting System for the Center for Medicare and Medicaid; RNA, ribonucleic acid; TB, tuberculosis.
have chosen to enter IDNs or larger practices. Two broad categories of GI practice have emerged in the last few years: 1) physicians employed by a larger health system and 2) physician-owned practices that affiliate with regional hospitals or health systems. Within these broad categories are 7 basic business models of GI practice (Figure 2).

When the first “mega GI group” was formed in the late 1990s, it was the largest integrated single specialty GI practice in the country. There are now more than a dozen GI practices with more than 40 physician owners, and in some areas of the country groups of more than 100 gastroenterologists are forming. Such consolidation will challenge the cultural and business attributes that have characterized gastroenterology practices in the last generation.

An emerging threat to the viability of independent GI practice is large IDNs that employ or contract with specialists and specialty groups. IDNs are forming to meet the challenge of value-based reimbursement and accountability for improved care. IDNs that assume clinical and financial risk will succeed only if they implement stringent clinical care algorithms, tightly control resource use, adopt cheaper alternatives to high-cost care (using fecal blood testing for primary colorectal cancer screening is an example), and reward practices that support their clinical mission on cost control and improved patient outcomes.

Cost

No one argues that health care spending in the United States exceeds that of any other country in the world. Arguments do occur when researchers or policy makers ask if US spending results in better care or health outcomes. Sectors of the federal budget that are both impactful and not irrevocably committed (fixed expenses) include health care, national defense, and education. They will inevitably have to compete for a diminishing pool of dollars as fixed costs of mandated programs (Social Security and Medicare) rise inexorably. The single component of health care most vulnerable to price compression is provider reimbursement. Sectors of medical care where there is clear evidence of variability in cost and quality will be early targets for intense management. Even a cursory reading of policy literature should alert gastroenterologists to the attention given to colonoscopy.

Articles mentioning colonoscopy consistently highlight the variability in cost and resource use seen across the United States and the lack of an obvious relationship between cost of the procedure and patient outcomes.

**Accountability**

Fee-for-service payment provides an incentive for physicians to deliver more, but not necessarily better, care. With increasing costs and the perception that US care is disorganized, disjointed, and wasteful, purchasers of health care concluded that providers should be more accountable for their decisions.

In the 1990s, financial risk (accountability) was shifted to providers through capitation contracts. Although capitation failed for a variety of reasons, the fundamental desire to couple financial risk to clinical decisions was never abandoned. In health care, there are only 4 entities (P’s) that can assume risk for medical decisions: payers (insurance companies), purchasers (employers or the federal or state governments), providers, or patients. Since the beginning of the insurance market in the early 1900s, “risk” has been passed back and forth among the 4 P’s on a regular and predictably redundant basis. The emergence of sophisticated risk adjustment, transparency of provider cost, and quality and information systems connecting administrative claims to clinical outcomes all have driven purchasers and payers to once again delegate significant risk to providers and patients in the form of “accountable care.” Like it or not, we will be on the hook for care we (and our primary and specialty colleagues) recommend in the next decade.

The formation of ACOs has been spurred by CMS-published rules, but questions remain about the legality of cooperative initiatives that contract for health care risk. There are 3 federal antitrust statutes that must be overcome to facilitate formation of ACOs. They include the Sherman Act 1 (agreements between economic entities that restrain trade), Sherman Act 2 (predatory or exclusionary conduct to monopolize), and the Clayton Act 7 (mergers and acquisitions that threaten to lessen competition). In addition to antitrust issues, Stark Laws limit physician self-referrals, and Medicare anti-fraud provisions limit incentive programs (civil monetary penalty). Welcome to the clarity of our future.

**Roadmap to the Future of GI Practice**

In their July 2011 strategy retreat, the Governing Board of the AGA Institute conducted an extended discussion of the 5 concepts presented above and tried to define how they might alter the practice of gastroenterology in both the community setting and in AMCs. A new 5-year initiative was created as a result of these discussions and was named the “Roadmap to the Future of GI Practice.” The fundamental purpose of this initiative is to bring together, in a coordinated manner, all parts of the AGA that would

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**Figure 2.** This figure illustrates 7 business models of gastroenterology practice as described in the article. Owner-operated practices are divided into sizes that correlate with differing business models and complexity of practice infrastructure. Examples of government practices include the Veterans Administration, Indian Health System, and others.
support members in their successful transition to the “Road Ahead.” Specific strategies envisioned are presented here briefly and will become topics of this CGH section in the months and years ahead. The Practice Management section of CGH is intended to provide a substantial and practical foundation for gastroenterologists to understand health care reform and implement changes in their practices to survive and thrive in a new environment. Information in this section will be augmented by a variety of online and print media coordinated by the Communication Department of the AGA and supplemented with guidelines and Clinical Decision Support tools and EMR modifications recommended by pertinent AGA committees including the Practice Management and Economics and Clinical Practice and Quality Management Committees. All will be informed and “reality checked” by the AGA “Think Tank for the Future of GI Practice,” a group of over 60 practicing clinicians that provide advice and probing to AGA leadership (additional members are welcome—please contact the AGA staff).

There are 5 basic components of the “Roadmap” that are being developed by the AGA (often in conjunction with our sister GI societies):

- **Performance Measures** populating the GI-NPMS. This is an example where close cooperation with the ASGE, AASLD, ACG, and CCFA has been crucial to develop a uniform set of evidence-based and endorsed accountability measures.
- **Infrastructure** for practices to demonstrate quality and value
  - Digestive Health Outcome Registry
  - Digestive Health Physician Recognition program
  - Collaborative payer incentive programs
  - Initiative to define EMR requirements for population management and standardization of data entry
  - Benchmarking standards of community and academic practice
- **Clinical Service Line Management Tools** (Clinical Decision Support Tools)
- **Clinical Care Guidelines**
- **Fellowship and Practitioner Education** that is focused on the triple aim, clinical integration, and accountable care.

Each will be described in detail in subsequent publications.

**Practice Management: The Road Ahead**

This article begins a new series designed to provide practical information for gastroenterologists who are looking to meet the challenges of health care reform in the next decade. We will coordinate with other forms of communication within the AGA. As articles appear, themes will be expanded and illustrated in various formats online or in other AGA printed material. Planned topics include how PPACA will affect AMCs and GI training, gastroenterologists’ future role in treatment of obesity, expanding the role of nurse practitioners, development of standard endoscopic data, how to choose an EMR, and ways to change your practice to manage clinical service lines through disease registries. We then will begin discussions about population management, gastroenterology care coordination within large IDNs, and the continuing consolidation in gastroenterology practices. This section editor does not know the future but will recruit intelligent colleagues to help us understand how to navigate successful paths to our continuing care of patients who need our skills, intelligence, and compassion.

**Supplementary Material**

Note: To access the supplementary material accompanying this article, visit the online version of Gastroenterology at www.gastrojournal.org, and at http://dx.doi.org/10.1016/j.gastro.2012.05.002.

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**Conflicts of interest**

The author discloses no conflicts.