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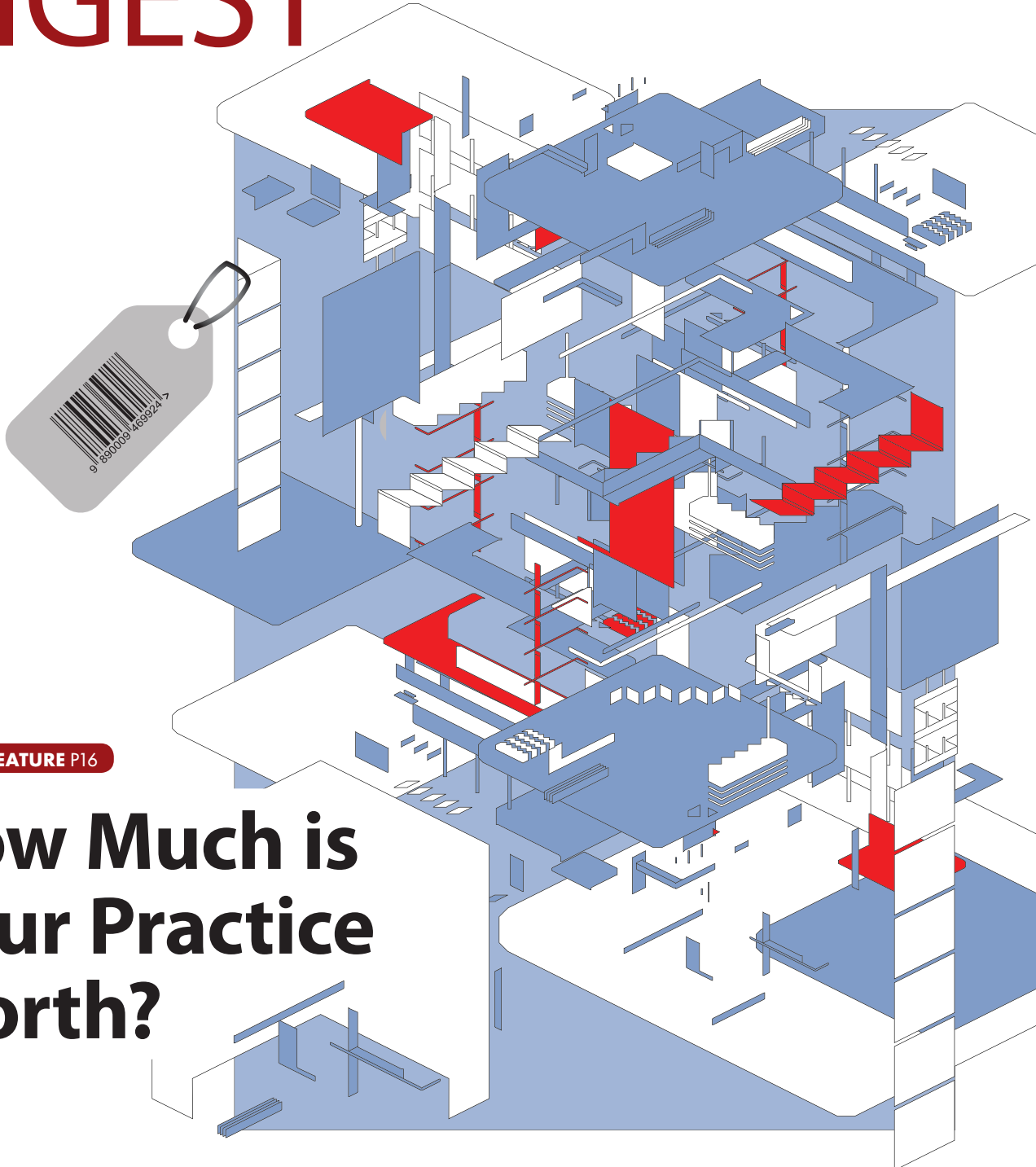
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AUGUST 2011

Contract Negotiations: 11
Tips for Negotiating with Insurers

ACOs: One Model for the Future: 20
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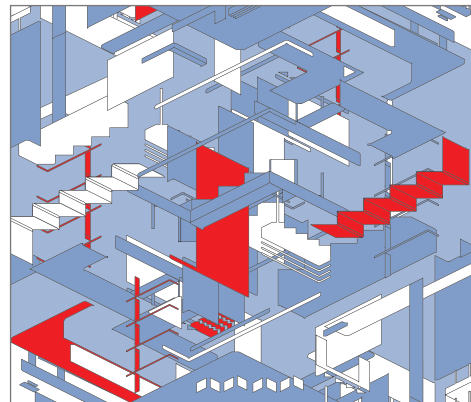
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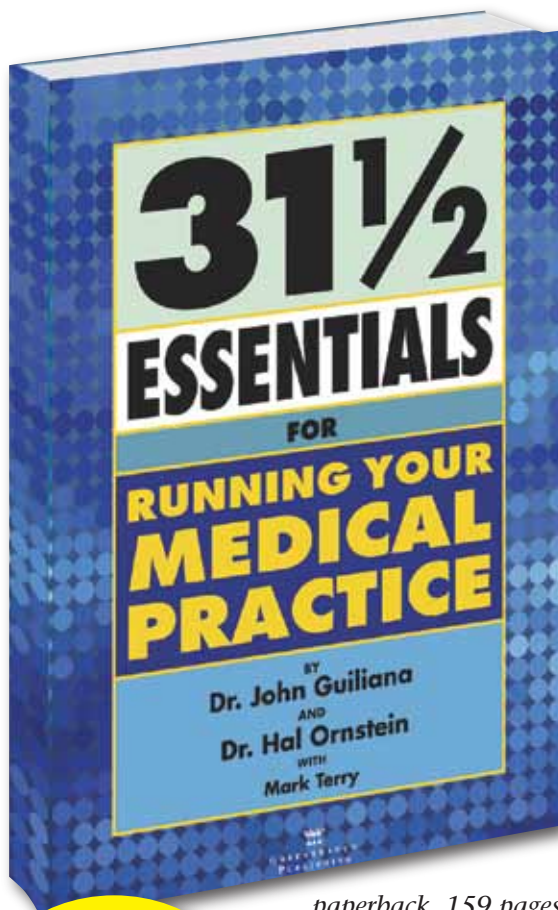
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Medical Practice News



Recertification May Delay Your 5010 Compliance

The Centers for Medicare & Medicaid Services (CMS) held its first National 5010 Testing Day on June 15. Shortly thereafter, Medicare administrative contractors (MACs) including Trail-Blazer, Highmark, and NHIC, Corp. began posting the top 10 submission errors specific to their respective jurisdictions. The results should serve as a lesson and a wake-up call for organizations that have not yet begun testing for Version 5010 compliance standards.

The MACs sliced and diced the data in several ways: for instance, listing 5010 submission errors by state, or for Medicare Part A claims vs. Part B claims. A few errors occurred consistently:

- The billing provider's submitter was not approved for electronic claim submissions on behalf of the billing provider
- Missing or invalid national provider identifier (NPI) or tax ID
- Duplicate submissions
- Invalid billing address or ZIP code information

Act Now to Correct Errors

"If you want to correct address errors, you need to begin now," says **Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC**, vice president of ICD-10 education and training at AAPC. The 5010 standard doesn't allow for post office (P.O.) boxes, she explains. The billing address must be a physical location, and requires a nine-digit ZIP code.

"Anytime you change your 'pay to' address—as providers currently using P.O. boxes will have to do—you must revalidate your Medicare credentials," Buckholtz continues. "Credentialing changes don't happen overnight. If your credentials and billing address aren't updated by January, you will be in a world of hurt."

CMS is stating that it does not process claims via address; however, you will want to be sure that you are credentialed correctly. For some payers, a letter outlining any changes might be sufficient. Other plans may require tedious paperwork. "If providers don't test early, they could suffer significantly when 5010 takes effect because it could take months to get credentialing errors fixed," Buckholtz says.

To prevent your payments from drying up, Buckholtz recommends that all Health Insurance Portability and Accountability Act (HIPAA)-covered entities conduct external testing to ensure timely compliance. The version 5010 compliance date is Jan. 1, 2012. The new standard is being implemented in two levels:

- Level I requires covered entities to test throughout the year, and to schedule testing as early as possible, to ensure sufficient time for corrective actions and re-testing.
- Level II requires covered entities to complete end-to-end testing with each of its trading partners, and be able to operate in production mode with the new versions of the standards.

Health Care Trends: Death of the Private Practice

A recent survey by Accenture concludes that physicians are increasingly moving away from private practice, choosing instead to sell their practices to, or work directly for, health care systems. American Medical Association's (AMA's) research shows the percentage of "truly independent" physicians has been declining by 2 percent annually, and by 2013 is projected to decline by 5 percent annually.

"Some are doing so to gain stability in an uncertain business environment or reduce their administrative responsibilities; others, to gain improved access to health care IT tools, facilities or equipment; still others, to gain a more manageable workweek," the survey overview states. "Hospitals, for their part, are aggressively acquiring physicians to lock in physicians and secure patient volumes."

Accenture conducted in-person and phone interviews with hospital executives and industry stakeholders September to November last year, and completed its analysis in 2011. The survey predicts that by 2013, less than one-third of physicians in the United States will remain in private practice, "and patients may increasingly find that being treated by physicians in private, small practice settings may be a thing of the past."

To see the survey details, go to: www.accenture.com/SiteCollectionDocuments/PDF/Accenture_Clinical_Transformation.pdf.

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By Stephen C. Spain, MD, FAAFP, CPC

Will **EHR** Provide **ROI** for Your Practice?

If you are struggling with an EHR decision, weigh the financial incentives and penalties, and plan.

Adopting an electronic health record (EHR) is a no-brainer for large practices and institutions. The need to share information and patients within a group requires that information be easily accessed and evaluated. Despite the costs and difficulties associated with moving to the EHR, most solo and two provider groups (which represent about one third of all medical providers in the United States) also should be anticipating the conversion. But depending on circumstances, certain smaller practices may wish to forgo an EHR.

Make a Calculated Decision

Cost is often the biggest reason providers object to EHR adoption. To ease the financial burden, the American Recovery and Reinvestment Act of 2009 (ARRA) calls for incentives of up to \$63,750 (depending on a provider's Medicare/Medicaid practice mix), paid as installments over a four- to six-year period. The incentives are not likely to offset the purchase price on an EHR system, but many EHR vendors are structuring their pricing to help customers minimize negative cash flow. A growing number of web-based EHR alternatives are priced as monthly services, which also can minimize initial expenses.

The ARRA also establishes penalties for providers who do not adopt an EHR, beginning as a 1 percent payment reduction in 2015 and reaching a maximum of 3 percent in 2017. A penalty for failing to adopt electronic prescribing, a common EHR feature, begins in 2012 and reaches a maximum of 2 percent in 2014. The penalties apply only to Medicare or Medicaid payments.

To illustrate the effect of the penalties, consider a practice that generates \$500,000 in annual revenue, of which 30 percent comes from Medicare. In this case, \$150,000 could be subject to penalties, for an annual loss in 2017 of 5 percent, or \$7,500. As the penalties are phased in, for the 10-year

period from 2011 to 2020, our non-adopting practice would be fined approximately \$47,000 (net expense). By contrast, an adopter paying \$8,500 annually for his EHR system would spend \$85,000 over that same decade. If that physician receives the maximum Medicare incentive during the same time (\$44,000), his net expense is \$41,000 ($85,000 - 44,000 = \$41,000$).

In our example, the net expense of the adopting physician and the non-adopting physician are not that different (\$47,000 vs. \$41,000). Your results may vary. Every practice struggling with an EHR decision should scrutinize its bottom line, weigh the financial incentives and penalties, and plan accordingly. For example, an adopting provider who qualifies for the Medicaid (rather than Medicare) incentive could receive \$63,750, rather than \$44,000, in incentives. Plugging that number into our example, an adopting provider would net approximately \$25,000 more than the non-adopter over a 10-year period.

Retirement Date May Drive EHR Decision

One of the first considerations when deciding whether to invest in an EHR is, "How long does the provider intend to keep practicing?" For reasons outlined above, if a solo physician has approximately five or fewer years to practice, the move to the EHR may be impractical. Moving to an EHR is arduous. For older providers, the financial incentives to adopt an EHR may not justify the emotional toll, lost productivity, and disruption to their practice routine.

Medicare and Medicaid providers for whom retirement is not in the foreseeable future should embrace the EHR within the next two years to take full advantage of available government subsidies. It makes little sense for younger providers to delay EHR benefits, which include tracking of disease markers, measuring practice benchmarks, improved legibility, portable information that is shared easily, elec-

tronic prescribing, drug interaction information, and allergy alerts. The expenses and disruptions associated with EHR adoption are lessening with each new generation of EHR software, and adoption now will avoid looming Medicare and Medicaid penalties for noncompliance, which could be substantial over a long career.

Many solo or two-provider groups are in the 50-year-old and older demographic, and a large number of those are clustered around the five- to 10-year retirement window. It is for these practices that the EHR decision is most difficult because, in this timeline, the cash incentives may not significantly offset the penalties for non-adoption.

Purchase options and payment methods for EHR systems vary widely, and the incentives available will differ greatly between practices. Several vendors have online calculators that allow visitors to input specific practice information to see what their incentive could be. The actual cash outlay for a given system may vary widely from the aforementioned examples. Likewise, penalties also will vary widely because of the differences in each practice's level of Medicare and Medicaid revenue. The point is, if you are a provider with only five to 10 years of practicing left, carefully weigh the costs of adopting versus the penalties for choosing not to comply.

The EHR revolution will have far-reaching effects. Not every provider can be expected to embrace the change, but each one can—and should—evaluate and plan for it. This preparation is a vital step in protecting the viability of small practices, as well as the livelihood of these health care providers. **MPD**



Dr. Spain has been engaged in the full time practice of family medicine for over 25 years. In 1998 he founded Doc-U-Chart, a practice management consulting firm specializing in medical documentation. Dr. Spain can be reached at sspain@docuchart.com.

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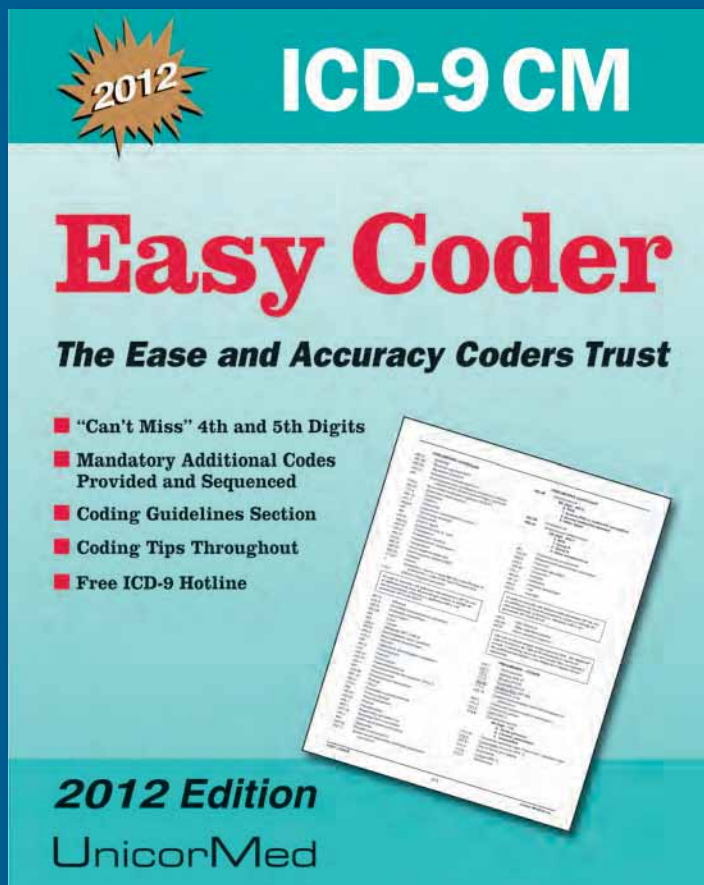
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By David Peters, CPC, CPC-P, PCS



Tips for Successful Contract Negotiations

Successful contract negotiations depend on research and effective communication.

Negotiating equitable payer contracts is essential to the success of your practice or facility. The advice of an attorney with health care experience is always a good idea, but if you use caution, avoid making assumptions, and take the time to understand what you read, you can handle much of the process on your own.

Trust, But Verify

Every state has its own regulations governing health care and contract requirements, and you should have at least a basic knowledge of these laws and rules as they apply to your organization. A good place to start is the website for your secretary of state, or the office that has oversight of insurance plans. In California, for instance, the Department of Managed Health Care regulates health maintenance organization (HMO) plans, and indemnity plans fall under the Department of Insurance. Federal law under the Employee Retirement Income Security Act (ERISA) regulates most self-funded plans. If an insurance company tells you that law requires certain contract language, don't just take their word for it—check for yourself.

A crucial first step in understanding a contract is to read the document carefully. Some contracts are written in complex legal terms, while others may be written in everyday language. If you don't understand the meaning of a word, look it up. For example, if you see *whereas* at the beginning of a statement, don't just gloss over it as “legalese.” It actually means *in view of the following facts*, and could put an entirely different spin on what follows. If you don't have an attorney at your disposal, a good legal dictionary is invaluable.

Put Your Thoughts on Paper

With a draft contract in hand, you're ready to begin your review. If you have a paper copy, pull out several highlighters of different colors. Use a green highlighter to mark portions of the contract that will have a financial impact. Use a red marker for those areas that aren't acceptable and will need to be addressed in negotiations. Highlight in yellow the sections you don't understand, or that will need clarification. If you are reviewing an electronic version of the contract, use the "Track Changes" (or similar) function to note your changes and comments, so they can be easily identified.

Pay close attention to "weasel words" (at least, that is what an attorney I once worked with called them). For example, terms such as, "will use best efforts" or "will attempt" are meaningless in a contract. Any such language must be clarified.

Another good tool is a list of your requirements, so you can check off those provisions as you encounter them. Anything on your list that doesn't get a check should be a matter for discussion.

Contracts with government agencies (for example, Medicare) generally cannot be modified. Private insurers may try the same approach, saying, "This is our standard contract that everyone signs." Don't let the conversation end there. A good response is, "It's a good start, but changes are needed before it's acceptable. How do we accomplish this?" You haven't said no, and you've let them know you are willing to negotiate.

The insurance company will expect you to:

- abide by and cooperate with their utilization management and quality assurance programs;

- not bill the patient for any money due from the insurance plan or charges, other than copayments and deductibles (This "hold harmless" language is often required by state regulation.);
- submit your claims in an acceptable format;
- provide services to their members just as you would any other patient;
- refrain from encouraging the patient to change to another insurance company; and,
- use a process such as binding arbitration to settle disputes, rather than going to court.

You, in turn, expect the insurance plan to pay your claims in a timely manner. Time limits are frequently regulated by the state, but beware: If your state mandates payment within 30 days of receiving the claim, and you agree to 90 days in the contract, you may forfeit your right to invoke the state regulation. You also expect the insurance company not to retroactively deny services that have been approved, and to get your permission before they use your organization's name in any marketing and advertising material.

Negotiate with a Smile

As the old saying goes, you catch more flies with honey than with vinegar. When entering into negotiations, be professional and non-adversarial. It helps to think of the insurer as a customer. Separate yourself from the issues, and weigh each proposal on its own merits.

If the payer initiated the request for a contract, they want you in their network and usually will be more willing to bargain than if you requested to be in their network. You'll want to make clear from the beginning what you have the

Insight from your coding and billing staff may be invaluable when negotiating the nitty-gritty of your contracts because they are in a unique position to anticipate problems.

authority to approve, and what will have to be approved from higher-up.

Prior to negotiations, calculate your office's direct costs for office visits and commonly billed procedures. To talk dollars and cents effectively, you must know your bottom line. Typical payment methodologies include:

- discounted fee-for-service, where you are paid a percentage of your billed charges (this method is becoming less common).
- payment based on the Resource Based Relative Value Scale (RBRVS) unit value, usually expressed as a percentage of Medicare.
- payment based on a proprietary fee schedule of the insurer's own devising. (In this case, you must provide the insurer with a list of your most common CPT® codes. The insurer will price the codes at their base value. You then can work on percentages of that base value.)

The body of the contract will also contain standard provisions that you need to understand and, if necessary, question:

Independent contractors—Language should not imply you are creating any type of employment, partnership, or joint-venture agreement.

Term—What is the initial term length

of the contract? Does it have an end date or does it renew automatically?

Termination—What are the provisions for terminating the agreement? Are there provisions for terminating for cause (breach of the agreement), as well as terminating if you no longer want to work with that plan (at will termination)?

Obligations after termination—How will patients be handled who are in the midst of care if the contract is terminated? How will you be paid for those services?

Dispute resolution—Often, the first step is a “meet and confer” between the two parties. If meet and confer is not successful, binding arbitration usually is a better solution than going to court.

Governing law—If you and the insurer are in the same state, there's no problem. If it's an out-of-state insurer, be sure the contract is compliant with your state's laws. If the contract is to provide federally funded programs, language must meet federal requirements (e.g., Health Insurance Portability and Accountability Act (HIPAA) and records availability).

Severability—This means it's possible to remove a portion of the contract if it's found to be in violation of the law or other regulations without invalidating the entire contract.

Amendments—Changes should be allowed only if mutually agreed upon and signed by both parties. Upon signing, the amendment becomes a part of the original document.

Call on Staff Expertise

Insight from your coding and billing staff may be invaluable when negotiating the nitty-gritty of your contracts because they are in a unique position to anticipate problems.

For example, suppose you are a small busy obstetrics (OB) practice without its own equipment to perform fetal non-stress tests (NSTs). Physicians must use the equipment at the local hospital to perform NSTs, but this is costly and time-consuming for physicians who must go to the hospital each time a patient shows up, unscheduled, with a possible complication. Knowing this, you may be able to negotiate with a payer an additional 25 percent reimbursement above the usual rate for an unscheduled NST.

That's good negotiating, but as your coder or biller might tell you, whether the NST is scheduled or unscheduled, you would report CPT® 59025 *Fetal non-stress test* with modifier 26 *Professional component* and place of service (POS) 22 *Outpatient hospital*. How will the payer tell the difference between a scheduled and unscheduled NST to ensure that you will receive the correct payment?

The time to find out if the payer has a system capability to trigger the higher payment is while you are still in negotiations. They might say you can bill 59025-26 with a second modifier of ET *Emergency services*, or some other coding modification. (Whatever works best for both parties frequently ends up being how the service will be coded, using standard procedures or not.) The point is: You want to recognize and resolve potential problem areas up front, and non-clinical staff may have practical knowledge to help.

Continue Working When the Ink Is Dry

Once contracts are agreed upon and signed, don't store them away in a dark closet only to collect dust. For instance:

- Keep your contracts in a central location in your office, so they are easily located.
- Create a tickler file for all of your contracts, with termination and anniversary dates. Check it monthly to keep current.

- Make a copy of the payment terms and other pertinent information for your billing staff. This will ensure your claims are billed correctly and make it easier to verify whether you're getting paid correctly.
- If your billing system can be programmed with your expected reimbursement, take the time to do it.
- Make sure the front desk staff has a current list of what insurances you accept in your office. Nothing will anger a patient quicker than hearing, "Sure, we'll bill your insurance for you," only to receive a bill for the full amount because the physician is out-of-network. If you're scheduling and the front desk staff has a list of contracted insurance plans, out-of-network patients can be forewarned that they may have a higher out-of-pocket expenses or minimal coverage. **MPD**

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The Anatomy of the Contract

Most contracts contain six components:

By David Peters,
CPC, CPC-P, PCS

1. The PREAMBLE is the opening statement. It names the parties to the agreement and usually indicates the legal status of each party (i.e., *John Smith, MD, an individual*, or *Local Medical Group, a limited liability corporation*). The preamble usually establishes a reference name for each party. For instance, “Great Big Insurance Company and All of Its Legal Affiliates (the COMPANY)” would be referred to as COMPANY, instead of the full name, throughout the contract.

The preamble also may contain the effective date of the contract. Contracts should never be postdated to cover previously provided services.

2. The RECITAL, or background statement, describes the purpose of, or reason for, the contract. The recital is typically no more than one paragraph and usually doesn’t require close scrutiny.

3. DEFINITIONS provide standard meaning for terms used throughout the contract, and are usually expressed in capital letters to reduce confusion. An example might be: “COVERED SERVICES means those *Medically Necessary* comprehensive health care services that *Enrollees* are entitled to receive pursuant to one or more *Service Agreements* with the *Prepaid Plan*.” *Covered Services* is now defined to have a singular meaning.

Because the above definition contains the terms “Medically Necessary,” “Enrollees,” “Service Agreements,” and “Prepaid Plan,” they also should be defined. If a definition is unclear, ask for clarification. Be wary if a company resists—purposefully vague terms may cause problems later.

4. OPERATIVE LANGUAGE is the body of the contract. It contains most of the provisions, and describes the obligations and responsibilities of both parties.

You should be able to identify key elements in the body of the contract. There should be a section for each party describing its obligations.

5. The SIGNATURE PAGE is sometimes the first page to allow for easy document storage and retention, but usually follows the terms of the agreement. Be sure all parties sign (and date) the same document, and have the proper authority to sign the contract. Usually contracts are done as “multiple counterparts,” which means there may be more than one original document, so both parties have an original document. The signature date may be the agreement’s effective date, but should not be after the effective date.

6. EXHIBITS or ATTACHMENTS is usually where payment rates and other information that may periodically change (such as a listing of the physician names in a group practice) are defined. Exhibits are easily amended, as needed, so the body of the contract isn’t changed.

Other documents may become a part of the contract by reference. One such document may be the payer’s provider manual. This will be noted by a statement such as, “*Medical Group* hereby agrees to follow and abide by the prior authorization requirements in *AA Insurance Provider Manual* included by this reference and hereby incorporated into this *Agreement*.” Be careful with these references. Provider manuals are updated regularly, and should a change significantly alter your obligation, you’ll need to amend or terminate the contract. ^{MPD}



David Peters, CPC, CPC-P, PCS, is contracts manager for Sutter Pacific Medical Foundation, in Santa Rosa, Calif.

How Much is Your Practice Worth?

Establish Your Practice's Fair Market Value

Part One of Medical Practice Valuation

By Dr. David Edward Marcinko, MBA, CMP, and Hope Rachel Hetico, RN, MHA, CMP

In recent years, the physician practice market has experienced a noticeable increase in practice merging and acquisitions. Medical practices are being acquired by health systems in anticipation of Accountable Care Organization (ACO) delivery models. For physicians, the decision to buy, sell, or merge a medical practice is more complicated than ever, and determining a medical practice's worth is crucial to this process. Over the next two months, we'll review the why, when, and how of the contemporary medical practice valuation.

Value Isn't an Absolute Number

A medical practice's tangible and intangible assets can be grouped into two broad categories:

- *Physical assets:* Examples are real estate, medical records, leaseholds, medical equipment and furnishings, and accounts receivable (A/R).
- *Non-physical assets:* These include goodwill, restrictive covenants, buy/sell agreements, managed care contracts, and an assembled workforce.

Estimates of value differ markedly, depending on the purpose of the appraisal, the acumen of the appraiser, etc. To help determine the value, some

important questions to consider are:

- What is the value of the practice for purchase or sale?
- What is the value of a practice for merger?
- What is the value of practice assets for joint venture with a corporate partner?
- What is the value to establish buy-in or buy-out arrangements for partners?
- What is the value of practice assets for purchase or sale, apart from ongoing operations?

To answer these questions, physicians (buyers and sellers) must understand how practices are valued—beginning with the following informal, and then more formal, definitions:

Informal Terms of Valuation

- The “asking price” is often arbitrary and difficult to substantiate, and typically is reduced 25-50 percent after negotiations.
- The “creative price” is derived by way of creative financing. For example, the practice may provide the down payment.
- The “emotional price” may involve either a motivated buyer or seller, who pays an under- or overinflated price for the practice.

- The “friendly price” is reserved for associates, partners, or other colleagues.
- The “realistic price” is one that both buyer and seller believe is fair.

Formal Terms of Valuation

- Most appraisers use “fair market value” (FMV) as the standard to derive a reasonable value for a practice. FMV means an arm’s length transaction between an unpressured, informed buyer and an unpressured, informed seller.
- The “business enterprise value” of a practice equals a combination of all assets (tangible and intangible), and the working capital, of a continuing business.
- The value of “owner’s equity” equals the combined values of all practice assets (tangible and intangible), less all practice liabilities (booked and contingent).
- The “working capital value” equals the excess of current assets (cash, A/R, supplies, inventory, prepaid expenses, etc.) over current liabilities (accounts payable, accrued liabilities, etc.).

Realizing that there is no absolute sales price is the essence of FMV. When determining valuation, look for a price range with a reasonable floor and ceiling.

Understand the Lingo

If you are a practice buyer or seller, make sure you understand terms and appraisal definitions.

That’s a lesson George Farmer, a primary care physician in Florida, learned the hard way. He asked his accountant to appraise his business. When he was

ready to sell, his attorney (who also happens to be his brother-in-law) drew up the sales contract. Farmer was pleased that the practice sold quickly for its full asking price.

What he didn’t know (but would discover) is that accounting or “book” value—the figure his accountant gave him—is far different than the FMV that he could have received.

Was the CPA wrong? Not really. Was the doctor incorrect? No. But each was operating under a different set of terms and definitions, without knowledge of each other’s perspectives.

How to Begin Valuation

The following steps should occur before the practice appraisal process begins:

- Retain an appraiser (for each side) who understands the changing health care industry.
- Aggregate historic practice business information and consolidated financial statements, operating statistics, payer mix, CPT® utilization, acuity rates, etc.
- Eliminate one-time, non-recurring expenses, adjusted or normalized for excessive or below normal expenses.
- Understand key assumptions used in financial projections.

To determine value, appraisers should follow the American Society of Appraisers’ *Principles of Appraisal Practice and Code of Ethics*. The IRS issued guidelines in 1995 further suggesting that appraisers use the general methods of the Uniform Standards of Professional Appraisal Practices (USPAP), which recognize three approaches to medical practice valuation.

1. Income Methods

There are two methods to value a practice by income:

(a) Capitalization Method: The excess earnings or capitalization method estimates value by dividing normalized historical or current income by an appropriate rate of return for the buyer. This method does not require assumptions.

(b) Discounted Method: Discounted Cash Flow (DCF): Analysis requires assumptions to estimate practice value by discounting future net cash flows to their present worth based on market rates of return required by an investor. Understanding the key assumptions produces a meaningful estimate of practice value. These assumptions may include:

- projections of future practice revenue, productivity, reimbursement trends, and shifts in payer mix
- projections of practice cost structures and projected physician compensation
- after-tax practice cash flows
- reinvestments to replace equipment or other assets
- residual practice value at the end of the forecast period
- discount rate based on the practice specific weighted average cost of capital
- practice efficiencies, operations, and competitive market conditions

The DCF analysis consistently produces higher values than other methods of estimating practice value because there may be supportable reasons to forecast improvements in future practice performance.

2. Marketplace Multiples

Market transaction multiples are ratios developed by correlating actual practice sale prices to key practice performance measurements. Common multiples include comparisons of sale price to revenue, sale price to earnings before interest and taxes (EBIT), sale price to earnings before interest, taxes, and depreciation allowance (EBITDA), gross revenue, net revenue, and the sale price to number of physicians.

Market transaction multiples are typically limited to serving as a benchmark for testing the reasonableness of the other approaches. They are becoming less common and less useful.

3. Cost Approach

The cost approach calls for identification and separate valuation of all the practice assets, including goodwill, depreciated over 15 years.

The cost approach is more labor intensive than using the enterprise analysis to estimate practice value; especially for a new practice, which typically includes the expenses to acquire space, office furnishings, equipment, marketing, advertising, staff development, and losses incurred during the startup period. This estimate of “replacement cost or cost avoidance” value represents an upper limit (or ceiling) of value, and generally is not considered useful in estimating the value of an established medical practice.

Net Income Statement Adjustments

When analyzing a set of financial statements to determine practice value, adjustments (normalizations) generally are needed to produce a clearer picture of likely future income and distributable cash flow. It also allows more of an “apples to apples” line item comparison. This normalization process usually consists of making three main adjustments to a medical practice’s net income (profit and loss) statement.

1. Non-Recurring Items: Estimates of future distributable cash flow should exclude non-recurring items. Proceeds from the settlement of litigation, one-time gains/losses from the selling of assets or equipment, and large write-offs that are not expected to reoccur, each represent potential nonrecurring items. The impact of nonrecurring events should be removed from the practice’s financial statements to produce a clearer picture of likely future income and cash flow.

2. Perquisites: The buyer of a medical practice may plan to spend more or less than the current doctor-owner for physician executive compensation, travel and entertainment expenses, and other perquisites of current management. When determining future distributable cash flow, income adjustments to the current level of expenditures should be made for these items.

3. Non-cash Expenses: Depreciation expense, amortization expense, and bad debt expense are all non-cash items which impact reported profitability. When determining distributable cash flow, you must analyze the link between non-cash expenses and expected cash expenditures.

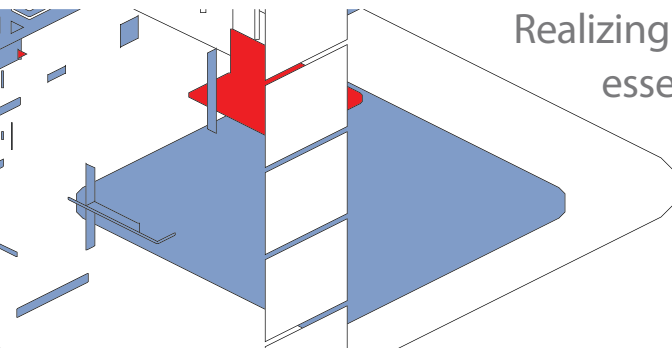
The annual depreciation expense is a proxy for likely capital expenditures over time. When capital expenditures and depreciation are not similar over time, an adjustment to expected cash flow is necessary.

Some practices reduce income through the use of bad debt expense rather than direct write-offs. Bad debt expense is a non-cash expense that represents an estimate of the dollar volume of write-offs that are likely to occur during a year. If bad debt expense is understated, practice profitability will be overstated.

Balance Sheet Adjustments

Adjustments also can be made to a practice’s balance sheet to remove non-operating assets and liabilities, and to restate asset and liability value at market rates (rather than cost rates).

Assets and liabilities that are unrelated to the core practice being valued should be added to or subtracted from the value, depending on whether they are acquired by the buyer. Examples include the asset value less outstanding debt of a vacant parcel of land, and marketable securities that are not



Realizing there is no absolute sales price is the essence of FMV. When determining valuation, look for a price range with a reasonable floor and ceiling.

needed to operate the practice. Other non-operating assets, such as the cash surrender value of officer life insurance, generally are liquidated by the seller and are not part of the business transaction.

With a basic understanding of practice valuation and the steps involved, buyers and sellers will be better prepared for next steps. Next month, we will discuss the art of the deal, and how to structure the practice sale. [MPD](#)

Additional Reading:

Cimasi, Robert James: *Valuation of Hospital in a Changing Reimbursement and Regulatory Environment*. In, Marcinko, DE (Editor): *Healthcare Organizations (Financial Management Strategies)*. Institute of Medical Business Advisors Inc., Atlanta, Ga., 2011

Marcinko, DE: "Getting It Right," How Much Is a Plastic Surgery Practice Really Worth? *Plastic Surgery Products*, August 2006.

Marcinko, DE and Hetico, HR: *The Business of Medical Practice* (third edition). Springer Publishing, New York, N.Y., 2011.

Marcinko, DE and Hetico, HR: *Risk Management and Insurance Planning for Physicians and Advisors*, Jones and Bartlett Publishers, Sudbury, Mass., 2007.

Marcinko, DE and Hetico, HR: *Financial Planning for Physicians and Advisors*, Jones and Bartlett Publishers, Sudbury, Mass., 2007.

Marcinko, DE and Hetico, HR: *Dictionary of Health Insurance and Managed Care*, Springer Publishing, New York, N.Y., 2007.

Marcinko, DE and Hetico, HR: *Dictionary of Health Economics and Finance*, Springer Publishing, New York, N.Y., 2007.



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AUGUST WEBINAR

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ACOs: One Model for the Future

An example of what challenges lie ahead.

By Kyla E. Wilson, CPC, CCS-P

In its recently announced Shared Savings Program, the Centers for Medicare & Medicaid Services (CMS) anticipates improved care for Medicare beneficiaries and lower costs for Medicare through the formation of Accountable Care Organizations (ACOs). The pressure is on providers and hospital systems to improve quality and efficiency, but a lack of proven ACO models leaves some observers wondering whether ACOs will succeed in the real world. Here we will discuss an example ACO and how well it conforms to the Shared Savings Program Notice of Proposed Rule Making (NPRM) that CMS issued at the end of March.

For more about ACOs and the shared savings NPRM, see “Have a Better Understanding of ACOs” in this issue of *Medical Practice Digest*.

Brookings/Dartmouth Provides a Model

Medicare defines an ACO as an “organization of health care providers that agrees to be accountable for the quality, cost, and overall care ...” of its patients. ACOs are a fairly new concept, with multiple pilot programs now underway. Of those, one of the most advanced is the Engelberg Center for Health Care Reform at the Brookings and Dartmouth Institute for Health Policy and Clinical Practice. Brookings/Dartmouth has been working with five pilot sites for the past two years to prepare a shared savings contract with private payer(s), including Anthem, UnitedHealthcare, and Humana. The groups are comprised of medical group/independent physician associations (IPAs), integrated delivery systems, and a physician-hospital organization.

The Brookings/Dartmouth ACO model is based on three key principals:

1. Local Accountability: By comprising groups that collaborate on local delivery of care, the ACO can manage continued care across patient encounters and settings (such as primary care visits, preventive services, hospital and nursing-home based care, etc.).

No one ACO model can be declared “the best” because many ACOs are currently in the pilot stage, with measurement and reporting outcomes yet to be determined.

CMS’ Shared Savings Program NPRM (or proposed rule) indicates that ACO participants must hold at least 75 percent control of an ACO’s governing body. The Brookings/Dartmouth group observes this requirement as part of its local accountability concept; however, this may be a challenge for smaller ACOs in rural areas without large health systems to contribute to ACO formation and infrastructure. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) are not currently eligible to

become ACOs under the proposed rule, but may be included as part of an ACO’s structure.

2. Shared Savings: The Brookings/Dartmouth group has formulated specific expenditure benchmarks for their ACOs, based on historical trending, and makes adjustments to account for patient mix. If the ACO meets the quality thresholds, and the expenditures are below certain benchmarks, the ACO is eligible for shared savings payments that can be distributed among the providers.

Per the proposed rule, ACOs may be eligible to receive a share of savings if their actual per capita expenditures for assigned Medicare beneficiaries are better than an ACO-

Eligibility and Structure Criteria

Per the Shared Savings Program NPRM, to be eligible to become a legally recognized ACO, a group must consist of:

- ACO professionals in a group practice arrangement;
- networks of individual practices such as an independent physician group;
- a partnership or a joint venture type of arrangement between a hospital system and ACO professionals; or,

- a hospital that employs ACO professionals. An ACO professional is defined as internists, family practice physicians, general practice physicians, and geriatric medicine physicians.

An ACO's leadership and management structure must include clinical and administrative systems and have defined processes that:

- (a) promote evidence-based medicine;
- (b) report on the necessary data to evaluate quality and cost measures; and,
- (c) coordinate care

specified benchmark. The benchmark will be based on the most recent three years of per beneficiary expenditures for Parts A and B services for Medicare fee-for-service (FFS) beneficiaries assigned to the ACO. Adjustments are made relative to beneficiaries' characteristics, risk, and health status by using prospective hierarchical condition categories (HCCs) currently applied to Medicare Advantage plans.

3. Performance Measurement: By measuring quality of care that ACO participants provide, Brookings/Dartmouth can ensure that cost savings do not come at the expense of patient outcomes and satisfaction.

The proposed rule requires tracking of at least 65 quality measures. In the first year, ACOs can meet performance requirements simply by submitting data for all 65 measures; after the first year, they will need to meet certain quality and performance standards on a sliding scale scorecard.

A significant challenge for any ACO will be updating practice management, electronic health records (EHRs), or internal ACO systems quickly enough to collect and report on the data necessary. Most EHR systems will have the ability to report on the quality measures from the recent "meaningful use" certification; however, reporting on some patient and caregiver experiences as part of an ACO, or measuring the sliding scale score for ACO performance levels, may be more problematic.

What the Future May Hold

Newly formed ACOs will need leadership and management structure to meet the goals of patient-centered health care, quality measurement, and efficiency. Much of the work will be centered on creating defined processes to promote evidenced-based medicine, and to facilitate reporting the data necessary to evaluate the quality and cost measures required under the proposed rule. This may give larger hospitals or

health care systems an advantage over small, independent physician groups. Large health systems can form alliances across separate distinct networks or create IPAs.

The Brookings/Dartmouth ACO is one example of a successful concept: Other models may be structured differently. No one ACO model can be declared "the best" because many ACOs are in the pilot stage with measurement and reporting outcomes yet to be determined. Physicians and physician groups considering an ACO should explore all the available options. For example, announced May 17, the CMS Innovation Center will support a new ACO model, available this summer, called the Pioneer ACO Model. This model offers a faster path to help already mature ACOs who are coordinating care for patients to move forward quickly. The model will work in coordination with private payers to achieve cost savings and improve quality. For more information regarding the Pioneer ACO Model, go to the CMS Innovations website at <http://innovations.cms.gov/>.

Physicians or groups that choose to join the ACO Learning Network (a program run by the Engleberg Center for Health Care Reform at Brookings and the Dartmouth Institute for Health Policy & Clinical Practice) will have access to more detailed information about creating ACO pilot site structures and different payment models, and can obtain information regarding some of the implementation barriers the ACO may experience. ^{MPD}

You can find more information at www.acolearningnetwork.org.



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Have a Better Understanding of ACOs

By G.J. Verhovshek, MA, CPC

Get the basics on shared savings programs to coordinate better patient care.

An Accountable Care Organization (ACO) is a group of health care providers (including facilities and suppliers) who work together to coordinate patient care. Think of an ACO like an auto manufacturer, which assembles its cars using parts from various subcontractors. The ACO provides overall direction and quality control, and assures the various parts work well together. The result is a better-integrated, higher quality, lower cost product than if the end user (the patient) had to gather and assemble the various components one at a time, by him- or herself.

To promote the positive outcomes that ACOs promise, Section 3022 of the Affordable Care Act requires the Centers for Medicare & Medicaid Services (CMS) to establish a shared savings program to facilitate coordination and cooperation among providers. The Shared Savings Program Notice of Proposed Rule Making (NPRM) appeared in the April 7, 2011 *Federal Register*. A final rule will follow later this year, with the Shared Savings Program expected to begin Jan. 1, 2012.

Providers can participate in the Shared Savings Program by becoming part of an ACO and applying to CMS (an existing ACO will not be accepted into the Shared Savings Program automatically). The ACO is a legal entity under state law, which will enter into a three-year agreement with CMS to be accountable for the quality, cost, and overall care of at least 5,000 Medicare beneficiaries assigned to it. To enjoy “shared savings,” participating ACOs must:

- meet certain quality standards, and
- produce actual cost savings.

Quality Measures Limited to Reporting for 2012

CMS is encouraging providers to participate in the Shared Savings Program in 2012 by setting the quality performance standard to reporting only. CMS has proposed to measure quality of care using five measures categories:

1. Patient experience
2. Care coordination
3. Patient safety
4. Preventive health
5. At-risk population/frail elderly health

These measures are aligned with other CMS programs, such as the electronic health records (EHRs) and Physician Quality Reporting System (PQRS). For example, any ACO that successfully reports quality measures required under the Shared Savings Program would also be deemed eligible for the PQRS bonus.

Shared Savings Can Become Shared Loses

Under the proposed rule, Medicare would pay individual providers and suppliers as it does currently under the fee-for-service (FFS) payment systems. To determine eligibility for additional, shared savings payments, CMS would develop a benchmark for each ACO. The benchmark is an estimate of what the total Medicare FFS Parts A and B expenditures

CMS is proposing to implement a one-sided risk model (sharing of savings only for the first two years, and sharing savings and losses in the third year) and a two-sided risk model (sharing savings and losses for all three years). Each ACO would be allowed to choose the model in which it wants to participate, but the incentives are higher to participate in the two-sided risk model (e.g., a 60 percent maximum sharing rate for the two-sided model, versus a 50 percent maximum sharing rate for the one-sided model).


The Department of Health & Human Services (HHS) estimates that ACOs could save Medicare up to \$960 million in the first three years. Although this amounts to less than one percent of Medicare spending during the period, HHS and

If an ACO meets quality standards and achieves savings exceeding the MSR, the ACO would share in savings; however, an ACO also might have to pay back Medicare if it fails to provide efficient, cost-effective care.

for ACO beneficiaries would have been in the absence of the ACO. The benchmark is updated each year, and would take into account beneficiary characteristics and other factors that may influence the need for health care services. Based on the benchmark, CMS would also establish a minimum savings rate (MSR) for each ACO. Expenditure savings must exceed the MSR if an ACO is to qualify for shared savings.

If an ACO meets quality standards and achieves savings exceeding the MSR, the ACO would share in savings; however, an ACO also might have to pay back Medicare if it fails to provide efficient, cost-effective care. Losses could occur if the ACO's quality performance score doesn't meet requirements, or if the per beneficiary cost is more than 2 percent higher than the benchmark. CMS has proposed a shared loss cap of 5 percent of the benchmark in the first year of the Shared Savings Program, 7.5 percent in the second year, and 10 percent in the third year.

CMS have embraced ACOs as one method to reign in health care costs. Many health care providers, meanwhile, have adopted a "wait and see" attitude, and remain concerned about unresolved questions (such as how ACOs encourage consolidation among providers and facilities, and how large ACOs or ACOs in rural areas with few providers may be treated under anti-trust regulations).

For more information on the Shared Savings Program NPRM, visit the CMS website (www.cms.gov/sharedsavingsprogram/). For more information on the upcoming final rule and how it will affect health care providers and organizations, keep watching *Medical Practice Digest*. 

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.

Six Steps to Effective PQRS Reporting

When delegation and management are done right, incentive payments are attainable.

By Shannon O. DeConda,
CPC, CPC-I, CEMC, CPMA,
CMSCS, CRTT

Revenue streams are down for physician practices across the country. During these challenging times, savvy practice managers are seeking additional revenue opportunities to improve the financial position of their practice. Physician Quality Reporting System (PQRS)—formerly the Physician Quality Reporting Initiative (PQRI)—is one such opportunity. An incentive program made available to providers by the Centers for Medicare & Medicaid Services (CMS), payments can yield a successful reporting practice with an additional 1 – 1.5 percent of Medicare reimbursement during designated periods in 2011. Remember the old adage, however: “There is no such thing as a free lunch.” It will take some work and diligence on your part—not to mention careful planning and teamwork—to attain this goal.

Start Walking

The following six steps will help guide you through the process of developing an effective working plan.

Step 1—Create a PQRS task force.

This will ensure you have the proper support you’ll need to achieve maximum bonus payments. Depending upon the structure and size of your practice, you may want to include the following members in your task force:

- Practice manager
- Billing/coding manager
- Clinical manager
- Physician representative

Step 2—Register at the CMS “Getting Started” page. Here you’ll find detailed steps for the registration and reporting process. You can find this information at www.cms.gov/PQRS/03_How_To_Get_Started.asp#TopOfPage.

The best individuals to decide which quality measures are the most appropriate targets for your practice population are the clinical personnel: physicians, non-physician practitioners (NPPs), and the nursing staff. Provide a copy of the quality individual/group measures to each of these individuals along with a timeline for their final recommendations.

The 2011 Physician Quality Reporting System (Physician Quality Reporting) Measures List can be downloaded at www.cms.gov/PQRS/Downloads/2011_PhysQualRptg_MeasuresList_033111.pdf and www.cms.gov/PQRS/15_MeasuresCodes.asp#.

Step 3—Consider your reporting options. With your billing manager, compare the claims’ option/electronic health record (EHR) reporting of PQRS to that of an outside registry. Based on your options, determine the approach that will yield the best results for your practice. In doing this, remember to evaluate necessary staff resources and hardware/software resources. If a registry is chosen, then your implementation plan may need to vary from these steps, depending on the registry’s requirements.

Step 4—Ensure accurate reporting.

Assign the billing manager with the task of ensuring proper HCPCS Level II codes and modifiers for the reporting measures are appropriately appended to the billing slip (encounter form, fee ticket, router, etc.). This will facilitate communication and help the clinical staff report how this element was affected through the patient's encounter on the given date of service.

Step 5—Train all clinical and billing/coding staff. Assign the clinical manager with the task of explaining to everyone the measures elected and the specific clinical aspects of the measure(s). Have the billing manager educate everyone on HCPCS Level II codes and modifiers and how to appropriately append the modifiers. The billing manager must assume the gatekeeper role with the data entry staff to ensure that the affected measures do not go unreported for designated Medicare patients who are affected. If a patient's billing is identified as not being appropriately designated with necessary HCPCS Level II codes and modifiers, the data entry clerk should immediately request this information from the clinical team.

Step 6—Stay on course. Choose the effective date for implementation, and manage each facet of involvement to ensure everyone does their part. Be sure to check the availability dates to qualify for the PQRS incentive because the full reporting session must be inclusive.

Keep Up the Pace

Six steps of delegation and management and PQRS reporting becomes a manageable process. CMS provides many excellent resource tools on their website, but all of these tools have a tendency to make the project seem overwhelming. Break the process

down into steps to divide and conquer, and your practice can reap the rewards of successful implementation.

For additional resources on PQRS, visit the CMS website at www.cms.gov/PQRS/01_Overview.asp#TopOfPage.

For more information on how to benefit from PQRS incentives, read the article "Is Claims- or Registry-based PQRS Reporting Right for You?" in July's issues of *Medical Practice Digest*. MPD



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The billing manager must assume the gatekeeper role with the data entry staff to ensure that the affected measures do not go unreported for designated Medicare patients who are affected.

Word on the Street

Each month we'll share what the word on the street is.

Fact or Fiction: Have you found the financial benefits of PQRS to be worth the effort?

Curious what your colleagues think? We'll pose the question; you share your experiences.

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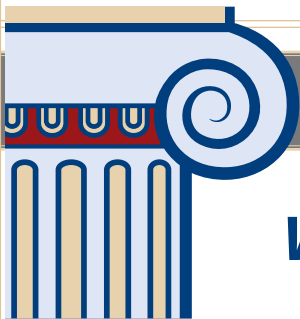
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Legal Forum

With RACs, What Are My Options?

Question:

If I receive a letter from a Medicare recovery audit contractor (RAC) regarding overpayment, do I have any options other than to pay up or launch an appeal?

Response:

Yes. According to **David M. Vaughn, JD, CPC**, of Vaughn & Associates, LLC, “42 CFR 405.374 allows the provider at least 15 days for an informal rebuttal before the formal appeal process starts. The typical RAC letter will state that you have 15 days to informally respond prior to the time the RAC submits its results to the Medicare administrative contractor (MAC), who then issues the formal demand letter. So, the first step in the process is to quickly figure out why the RAC is incorrect, and advise it within 15 days; and, if you are correct, the RAC will correct the audit mistakes and reissue a revised letter to you and the MAC.”

Section 405.374 “Opportunity for rebuttal,” states:

(a) General rule. If prior notice of the suspension of payment, offset, or recoupment is given under § 405.372 or § 405.373, the Medicare contractor must give the provider or supplier an opportunity, before the suspension, offset, or recoupment takes effect, to submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. Except as provided in paragraph (b) of this section, the provider or supplier has at least 15 days

following the date of notification to submit the statement.

(b) Exception. The Medicare contractor may for cause:

(1) Impose a shorter period for rebuttal; or

(2) Extend the time within which the statement must be submitted.

Vaughn, who has defended several RAC audits said, “All the ones I’ve defended do have the 15 day limit in their letter. I have used it successfully once, where the RAC made a mistake denying over \$100,000 in services as ‘services not rendered’ when the real issue was that the incident-to rules weren’t followed, but the services should have been allowed in the name of the NP. They reversed that component of the audit before submitting the demand letter to the MAC. In that case, I actually called them and got an extension of the 15 days, and they granted it. I then submitted our position in writing, and they agreed.”

Michael D. Miscoe, Esq., CPC, CASCC, CUC, CCPC, CPCO, CHCC, founding partner of Miscoe Health Law, LLC, said in his experience, mostly with zone program integrity contractors (ZPICs), “this is a permissible step but given that it has such a low chance of success, my concern in recommending it to a client is that it will only create additional expense with little chance of reward. While legally permissible, a poll of some of my colleagues and mentors suggest that other than the case mentioned by David, none have ever found any value in it.”

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Vaughn agrees there is less chance of its effectiveness with ZPICs, as opposed to RACs. “The rebuttal process is less likely to be successful for a ZPIC than a RAC audit,” Vaughn said. “The RAC audits—I have never had one where at least 50 percent of the initial determination wasn’t overturned at some point in the appeals process—are designed to capture ‘low hanging fruit,’ and there is less investigation that goes into those as compared to the ZPIC audits. The ZPIC auditors are generally more knowledgeable and spend more time in their investigation, whereas, the RAC audits are often computer generated, with a lot of unfounded assumptions.

“RACs are fairly inaccurate—unlike the ZPICs, which are much more accurate in my experience—so I think the rebuttal process can be a good tool with the RACs, not ZPICs.”

Miscoe added, “I would generally use this only when the client intended to pay, but there was concern about blind acceptance of the audit result leading to allegations of knowledge of the error down the road. The bottom line is:

- Providers should weigh (with the advice of counsel) the expense vs. the benefits of attempting a rebuttal rather than a formal

appeal. Engaging in this process is more likely to be successful in response to a RAC audit with obvious errors.

- In cases where the provider chooses not to appeal when faced with a minimal refund demand (as in a probe audit), the rebuttal process is a mechanism for putting your objections to the audit findings on record. That way, mere payment cannot be construed later as agreement (and knowledge as in False Claims Act context) with the audit result.” **MPD**



David M. Vaughn, JD, CPC, is the founding member of Vaughn & Associates, LLC. He graduated from Mississippi College with Special Distinction (Magna Cum Laude) in 1974, graduated from

LSU Law School in 1977, and has been a certified coder since 1999. Vaughn is the author of several coding and compliance books, and is the editor of a coding newsletter. He is a national speaker for health care associations and facilities. His practice consists of representing providers in federal and state prosecutions, qui tam cases, and Medicare and third-party payer audits. He also conducts audits and provides education to providers.



Michael D. Miscoe, Esq., CPC, CASCC, CUC, CCPC, CPCO, CHCC, has a bachelor's of science degree from the U.S. Military Academy, a juris doctorate degree from Concord Law

School, is the president of Practice Masters, Inc., and the founding partner of Miscoe Health Law, LLC. He is a past member of the AAPC National Advisory Board (NAB) and is a member of the AAPC Legal Advisory Board. He is admitted to the Bar in California and to the practice of law before the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. Miscoe has nearly 20 years experience in health care coding and over 13 years as a compliance expert testifying in civil and criminal cases. He has an extensive national speaking background and has been published in numerous national publications on a variety of coding, compliance and health law topics.

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Have a Legal Question? Ask Our Experts.
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Medical Practice News

Continued from page 7

Google Health Retires

Internet giant Google announced it is retiring Google Health—its online version of a personal health record (PHR) platform, where consumers can organize their medical records. First launched in June 2008, Google said, “We’ve observed that Google Health is not having the broad impact that we hoped it would.” Regardless of the outcome, however, the company said it was a worthwhile venture. Although Google Health “didn’t catch on the way we would have hoped,” the company said it did serve as an influential model for PHRs.

Responding to the news, NoMore-Clipboard President Jeff Donnell

said, “Google Health has been a great partner, and they have helped raise awareness of the value of personal health records. We are sorry to see Google Health leave the personal health space at a time when patient engagement is gaining traction.”

According to an IDC Health Insights study released in June, only about 7 percent of the public have ever used a PHR. Industry stakeholders are saying, however, that as more providers adopt electronic health records (EHRs) and participate in health information exchanges, PHRs will become more useful and gain popularity.

Google will shut down Google Health Jan. 1, 2012. Google Health consumers will be able to transfer their information and data to another PHR platform, such as Microsoft HealthVault, WebMD, or NoMoreClipboard through Jan. 1, 2013. After that, any data that remains in Google Health will be permanently deleted. Most recently, Google has added the ability for consumers to directly transfer health data out of Google Health via the Direct Project protocol, an open standard for health data exchange. **MPD**

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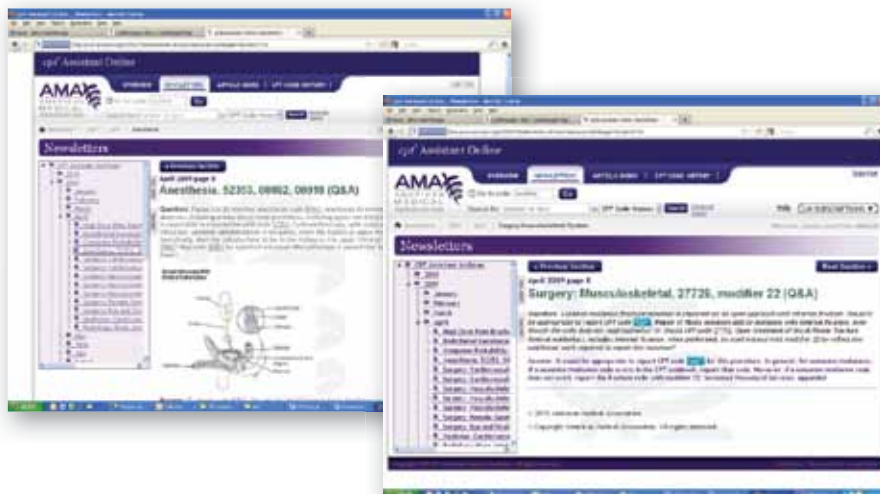
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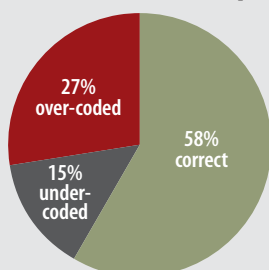
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