Responding to Reduced Reimbursement

How to Combat Industry Changes and Reductions in Medicare Reimbursement

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Current State of the Market

J. Everett Wilson

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Current State of the Market

Decrease in Physician Revenues Due to:

- Medicare and Medicaid
  - Mandatory reductions in Medicare physician reimbursement
  - Medicaid reform and elimination of MediPass

- Managed Care Organizations, Health Insurers and other Third Party Payors
  - Decrease in reimbursement related to reductions in Medicare physician fee schedule
  - Increase in co-pays and deductibles
  - Decrease in covered benefits

- Health Records
  - Reduction in Medicare and Medicaid payments if physicians do not convert to electronic and portable health care records within 5 years
Current State of the Market

Decrease in Physician Revenues Due to:

- **Economy**
  - Patients deferring routine medical care
  - Decrease in elective procedures
  - Decrease in non-covered procedures
  - Decrease in patients with insurance
  - Slower collection of monies due from patients

- **Health Care Reform**
  - Expected comprehensive legislation resulting in overall reduction in provider reimbursement
Current State of the Market

Continued Increase in Operational Costs

• Expenses associated with reimbursement:
  – Costs associated with dealing with requests from Medicare, Medicaid and managed care organizations (e.g. demand for records in connection with claims review)
  – Additional staff required to deal with payors (e.g. pre-authorizations, wait times and special requests)
  – Increase in costs of regulatory compliance (e.g. fraud and abuse and Stark)

• Increased cost of living affecting office operations and staff (e.g. benefits and malpractice)

• Costs for technology initiatives (e.g. electronic health records, insurance verification via the web, and other e-initiatives)
Current State of the Market

Physician Alternatives and Potential Solutions

• Sell practice and/or become an employee of hospital system or physician services company

• Find other sources of revenue
  – Apply for stimulus money for electronic health records
  – Form or join a large practice group
  – Contract with managed care organizations (e.g. capitation or assumption of risk)
  – Establish a concierge practice
  – Form or join an Independent Practice Association ("IPA")
IT’S A NEW WORLD!
2009 HITECH Stimulus Law

Ralph Losey
IT’S A NEW WORLD!

The Problem

- It is now government policy for all health care records to be computerized and portable in five years

- If you do not comply, then by law in 2015 your Medicare and Medicaid payments will be reduced
IT’S A NEW WORLD!

What Are Your Options?

- DO NOTHING and make even less money in 2015, forward

- CHANGE YOUR PRACTICE to stop taking any Medicare or Medicaid

- PROCRASTINATE until 2015, and if it is still the law, then change

- START TO CHANGE NOW and qualify for Government Incentive Payments under less stringent standards
What Kind of Government Incentive Payments?

$36.0 billion

Physician and Hospital Incentives
Bonuses from Medicare/Medicaid For Meaningful Use of EHR

+ $2.0 billion
HHS Discretionary Funds

- $18.5 billion
Savings Through Improved Efficiencies, Tax Revenues, and Penalties

_____________

= $19.5 billion
Health Information Technology for Economic and Clinical Health Act - HITECH ACT

Net appropriation of $19 billion for health information technology
Also includes HIPAA-2 provisions
IT’S A NEW WORLD!
HITECH Act: Incentives

First Adopters Will Benefit The Most (Sliding Incentives)

- Professionals can earn up to $44,000 from Medicare, or $64,000 from Medicaid, over five years
- Stimulus Payments begin in 2011, but requires planning now
- “MEANINGFUL USE” Certification Criteria will be a “rising tide” after 2012
- Draft Regulations for Meaningful Use certifications are 556 pages
- FYI - Hospitals can earn from $5 Million to $27.5
IT’S A NEW WORLD!
Medicare Penalties

Penalties begin in 2015 for professionals Not Certified as “meaningful users” even if they have purchased certified software/hardware
IT’S A NEW WORLD!
Who Can Apply for Medicare Incentives?

Medicare or Medicaid Providers.
• Bill at least $25,000 per year

Professionals: defined as physicians, dentists, podiatrists, optometrists and chiropractors
• Excludes hospitalists
• Includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, clinical social workers, psychologists, registered dietitians or nutritionists, etc.
IT’S A NEW WORLD!
Medicare Pays 75% Premium Until Yearly Cap is Reached

$18,000 + $12,000 + $8,000 + $4,000 + $2,000
$44,000 Per Professional
IT’S A NEW WORLD!
Questions?

I need incentives to go digital!
But what is it going to cost me to get my Stimulus Money?
Formation of a Large Practice Group

Marshall Burack
Formation of a Large Practice Group

Large Group Practices are the Exception; Not the Norm

- Nearly 50% of physicians work in a 1 or 2 physician practice
- Only 20% of physicians work in a practice with 10 or more physicians

Large Practices are a Relatively Recent Innovation

- Mayo Clinic – 1880's
- Most early group practices in rural areas
Formation of a Large Practice Group

Benefits of a Large Practice

- LEVERAGE WITH HEALTH PLANS
- Economics of scale
- Leverage with hospitals
- PROFIT FROM ANCILLARY SERVICES
- Better life style
- Quality of care

- Shared expertise and shared clinical systems
- Joint venture opportunities
- Chronic disease management
Formation of a Large Practice Group

Barriers to Large Medical Group Practice

- Lack of physician cooperation
- Inadequate capital
- INADEQUATE PHYSICIAN LEADERSHIP
- Cost of regulatory mandates for capitated patients
- Failure to manage costs for capitated patients
- Failure of other groups
- Conflicts between primary care and specialist physicians
- INADEQUATE BILLING AND COLLECTION SYSTEMS
Formation of a Large Practice Group

Regulatory Requirements

• Group Practice
  – Single legal organization (a unified business with centralized management)
  – Billing under a single billing number
  – Income distributed in accordance with predetermined methods

• Ancillary Services
  – Furnished or supervised by a member of the group
  – Billed under the group's billing number
  – Profits may not be distributed based on referrals
Formation of a Large Practice Group

Getting Started

- Identify potential members
- Select a leadership group
- Obtain sufficient capital
- Hire a management consultant
- Select IT hardware and software
- Engage a qualified attorney
Medicare Managed Care

Gary Matzner

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Medicare Managed Care

- Summary of Benefits for MAP Physician
  - NO BILLING
  - PREDICTABLE MONTHLY INCOME
  - ADDITIONAL BENEFITS TO PATIENTS AT NO COST TO PHYSICIAN (e.g., no or lower copays, no or lower deductibles, wellness, vision, and fitness benefits as well as access to discounts on health related services)
  - HMO ADMISSION TEAM ACCESSIBLE TO PHYSICIAN
  - MORE FREE TIME DUE TO HMO SUPPORT
  - INCREASED REIMBURSEMENT
Medicare Managed Care

- Concerns for MAP Physician
  - Patients Must Use Plan Specialists and Hospitals
  - Must Follow Managed Care Protocols
  - Risk Contracting Pool Deficits
  - Control of Patients
# Medicare Managed Care

<table>
<thead>
<tr>
<th></th>
<th>FFS (PER PATIENT)</th>
<th>MAP (PER PATIENT)</th>
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<tr>
<td><strong>INITIAL VISIT REIMBURSEMENT</strong></td>
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<td><strong>FOLLOW UP VISITS REIMBURSEMENT</strong></td>
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<tr>
<td><strong>AVERAGE VISIT PER YEAR</strong></td>
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<tr>
<td><strong>MANAGED CARE REIMBURSEMENT PER MONTH</strong></td>
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<tr>
<td><strong>TOTAL YEARLY REVENUE PER PATIENT</strong></td>
<td>$210 - $430</td>
<td>$1200 - $1680</td>
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<tr>
<td><strong>TOTAL YEARLY REVENUE</strong></td>
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<td></td>
</tr>
<tr>
<td>*350 PATIENTS</td>
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</tr>
<tr>
<td></td>
<td>$150,000</td>
<td>$420,000 - $588,000</td>
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Medicare Managed Care

- But I'm not a PCP!
- Who does the patient call when they have the Flu?
- Family Medicine/Primary Care
- Cardiologist
- Internist
Medicare Managed Care

- Risk vs Non-Risk Contracting
  - Start Non-Risk Until You Understand the Difference between FFS Mentality and Managed Care Mentality
  - Look for Opportunities with Smaller Plans
  - Make Sure that You Keep Control of the Patient
  - Beware of Reserve Fund Accounting
  - Risk Benefit for Well Managed Practice $50 to $200 PMPM or for Practice with 350 Members $210K to $840K per year.
Concierge Medicine
New Twists

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Concierge Medicine – New Twists

- Traditional Concierge Concept
  - Also known as Boutique Medicine or Retainer Practice
  - Patients pay Physician annual retainer fees of $50 to $20,000, Typical $900-$2,000
  - In exchange for guaranteed heightened access to health care services and amenities
  - May include: Executive Physical, 24/7 Access to Pager, Cell, or to Physician on secure website, Next day appointments, Extended time with Physician, Wellness, Spa-type amenities
  - Limited number of patients
Concierge Medicine – New Twists

- Franchise or Do it Yourself
  - **MDVIP** – Florida Based
    - Executive Physical, Access to Top MDs and Hospitals around the country, Quick Access 600 patients per MD
    - $1,500 Annual Fee $1K to MD $500 to MDVIP
  - **MD²** – Seattle Based – Original Concierge company
    - PCP – 50 families per Physician
    - No Insurance accepted – Same day appointments – Spa-type amenities. Annual fee range $14-20K
    - Franchise for $75K + 5% licensing/royalty
Concierge Medicine – New Twists

• Legal Issues
  – Medicare
    - Prohibits charging additional fees for Covered Services
    - Anti-kickback, can't offer remuneration to induce joining, amenities must be fair market value
  – Managed Care
    - Breach of contract which provides that MCO payment is payment in full
  – State Insurance Laws
    - Providing services for fixed prepaid fee may be considered a Managed Care Plan and subject to licensure
Concierge Medicine – New Twists

- New Twists-
  - Hybrid Plan
    - Combines Concierge and Traditional Into One Practice
    - Continue to See All Patients – Does not Force Patients to find a new Physician
    - Limit concierge Membership – set aside portion of each day
    - Example 200 Members @ $1,500 = $300K additional revenue
Concierge Medicine – New Twists

- Discount Medical Plan
  - Discount medical plan (FS 636.202) means in exchange for fees, dues or charges, the plan provides access for members to providers of medical services and the right to receive medical services from those providers at a discount
  - A Physician who provides discounts to his or her own patients is exempt
  - Allows a Physician to provide a combination of non-covered services and concierge amenities to Physician's own patients
  - Screening Tests, BMR, or CIMT
Independent Practice Associations ("IPAs")

Joseph Rugg

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What Is An IPA?

- An IPA is an organization created and owned by independently practicing physicians.
- The IPA does not provide health care services itself; it is **NOT** a large group practice.
- IPAs are based on the premise that a group of better informed and more unified physicians will get better managed care contracts.
- The primary goal of an IPA is to assist individual physician practices in leveling the playing field with managed care organizations ("MCOs") in order to get better contracts, increase their patient base, and improve their reimbursement rates while at the same time, maintaining their practice independence.
Independent Practice Associations

Characteristics Of IPAs

- An IPA provides a platform for combining a number of independent physicians and physician groups in order to negotiate more effectively with MCOs.
- In an IPA, there is the very limited integration among the practices of its members.
- An IPA represents its physician members in dealing with MCOs, while its members maintain their practice independence, and the IPA exerts little or no control over how its members practice.
- An IPA can be open to primary care physicians and specialists or its membership can be limited based on a practice specialty.
- Some members of an IPA will typically be competitors of other members.
- An IPA can have exclusive membership (meaning it does not permit its members to join other IPAs and does not admit everyone who wants to join) or non-exclusive membership (meaning that its admission policies are open and it does not prohibit its members from joining other IPAs).
- An IPA may or may not impose some financial risk on its members.
Independent Practice Associations

Antitrust Laws

- The Antitrust Laws have many layers and are quite complicated, but the basic thing to remember is that they prohibit competitors from agreeing to fix prices, to divide up the market they compete in, to engage in boycotts, or otherwise to compete unfairly.

- Because IPAs are formed to facilitate contractual relationships between their physician members and MCOs, they are subject to the Antitrust Laws.

- How the Antitrust Laws apply to an IPA depend in part on the characteristics of the IPA (e.g., how independent and non-integrated are its members, is the IPA exclusive or non-exclusive, do members compete with each other for patients, etc.).

- In most cases, the Antitrust Laws will impose significant limitations on an IPA’s ability to bargain with MCOs.
THERE ARE SEVERE CRIMINAL AND CIVIL PENALTIES FOR VIOLATING THE ANTITRUST LAWS.

There are many instances, often because of the complaint of an MCO, where agents from the DOJ and FTC have investigated an IPA and interviewed its physician members.
Reality And Guidance

- DOJ and FTC understand the imbalance in the bargaining power between physician practices and MCOs and agree that certain pro-competitive benefits may be attained with a more level playing field.

- The DOJ and FTC have published certain guidelines or "Statements" in order, among other things, to help guide the operations of IPAs to avoid violating the Antitrust Laws.

- IPAs will be evaluated by a "rule of reason" analysis:
  - What is the relevant market?
  - What are the pro- and anti-competitive effects?
  - How are providers included or excluded and with what effect?
  - Are the anti-competitive effects balanced by market efficiencies?
IPAs That Share Financial Risk Or Are Clinically Integrated Will Typically Be Given More Leeway In Dealing With MCOs.

- IPAs can share financial risk by providing services at a capitated rate or at a percentage of premium
- By providing financial incentives (and disincentives) to their members based on quality, utilization, and cost containment goals
- By providing complex or extended treatment regimens that require substantial coordination at a global fee or all inclusive rate

What can these IPAs do?

- The physician members can share with each other specific rate and procedure information
- Based on this information and the shared financial risk, the IPA can negotiate directly with the MCO on behalf of its physician members to achieve uniform contractual terms and acceptable reimbursement rates
Independent Practice Associations

Messenger Model Alternative

- Many IPAs neither share financial risk nor are clinically integrated. Nonintegrated/non risk sharing IPAs cannot usually negotiate price terms directly with MCOs.

- "Messenger Model" provides an alternative methodology for these IPAs to deal with MCOs.

- IPAs can engage a messenger (unaffiliated with any member physician) who will distribute to all members information from an MCO.

  - The Messenger can gather fee requirements from members (cannot disclose to other IPA members) and share requirements with MCOs and the number of providers available at a certain rates.

  - The Messenger can **NOT** negotiate rates with MCOs but can disclose to members the revised contract rates from the MCO and certain other information.

  - The Messenger, under certain circumstances, can be empowered to sign on behalf of members who accept the MCO's rates/contracts.
IPAs Are Becoming Popular Again

• IPAs are a friendly and unobtrusive way for physicians and physician groups to explore the benefits of a larger organization to improve contracts with MCOs and to increase reimbursement rates

• Many MCOs desire the efficiencies of being able to contract with many physicians through a single entity

• Through their group purchasing power, IPAs can be used to provide other benefits for its members, such as better rates for malpractice and group insurance

• There are cons to IPAs: the Antitrust Laws and limitations to the messenger model; no control over physician members; no structure and limited leadership; limited staff and professional assistance; free riders; competition with other members; members joining multiple IPAs; and members contracting separately from the IPA

• IPAs can be an initial step in a physician’s exploration of establishing or joining a large fully integrated group practice