Challenges of Neurologic Private Practice

Todd D Levine, MD
Assistant Clinical Professor of Neurology, University of Arizona
Adjunct Professor of Neurology, Kansas University
Phoenix Neurological Associates
How Did We Go From This…
To This
History of Reimbursements in Neurology

- Medicare, part B, was created in 1965 to provide relief for patients
- It was a fee-for-service model
- Physician payments under Medicare rose by 18% annually from 1965 and 1987.
- Raised the question of whether physicians were providing more services
- This fee for service model propagated the development of physician owned private specialty hospitals and diagnostic centers which financially impacted community hospitals and began to lead to the loss of small hospitals.
History of Reimbursements in Neurology

• In 1983, the Federal government changed the way hospitals were reimbursed by Medicare by formulating the Diagnostic Related Groups (DRGs) to provide incentive to deliver efficient care and discharge patients rapidly.

• Previous systems of payment provided no incentive to limit length of stay.

• In one study in New Jersey DRG reimbursement suggested a savings of 14% per admission and 9.8% per day and shortened LOS by 6.5%.
History of Reimbursements in Neurology

• The new reimbursement system caused major shifts in the way healthcare was delivered

• Shifted many neurological services to the outpatient setting. Hospitals were disincentivized to keep patients in house for evaluation

• Also placed even more importance on the role of rehab and SNFs to minimize hospital readmissions
History of Reimbursements in Neurology

- Shifts in health care services for neurological diseases
  - Inpatient services have been shifted to primarily outpatient care
  - As an example, Alzheimer’s patients live nearly 10 years after their diagnosis
  - In 2012 estimated expense of Alzheimer’s patients was $200 Billion
    - Why have neurologists captured so little of this and other “pies”
  - Demand for multidisciplinary range of services including physical, medical and psychological needs
History of Reimbursements in Neurology

• Managed Care Organizations attempted to reform the traditional fee-for-service model. But in the 1990s they were criticized for withholding medically necessary services.

• Hospital revenues began to fall so in 1989 the Federal Budget introduced a new method to calculate payments using a resource-based relative value scale intended to control cost increases.

• This reimbursement formula instituted identical payments for services regardless of whether they were performed by a generalist or specialist. It was designed to limit the number of expensive procedures.
History of Reimbursements in Neurology

- The RVU system drastically shifted reimbursements
- From 1991-1997 reimbursement to family physicians increased by 35% but decreased to ophthalmologists by 18%
- EMG reimbursement cuts were part of this ongoing effort to slash reimbursement for costly procedures

86% of neurologists stated they were negatively impacted by the decreases in EMG reimbursement

Reduction in revenue estimates are 25-35% for the average neurologist
So It's No Wonder Neurologists Feel Like the Last 20 years the Government has had it In For Us
Physician Care

- $515 Billion in 2010 representing the work of 750,000 providers (Martin 2012)
- The last 10 years have seen the physician community in turmoil
- Physician visits have fallen by 10% since 2007, while practice overhead has risen sharply (IMS Health 2011)
- Healthcare reform has deepened physicians concern for their future. 2/3 of physicians have negative views of the law (Merritt-Hawkins 2011)
- Congress has still not resolved the Balanced Budget Act’s Sustainable growth rate (SGR) formula
What is Happening to Private Practice

• Ground rules:
  • Income will be controlled
  • Expenses will adjust with market
  • Who would accept this as a viable business model?

• Billing requirements
  • Office staff in the US spends 8 times as much time on billing as Canadian office staff
  • Total billing costs are estimated at $85,276 per full time physician (Sakowski 2009)
What is Happening to Private Practice

• Physician reimbursement
  • 50% of physicians say they make less than they did 3 years ago
  • Only 18% said their income has increased
Something has come between us and our patients

- 2.5 Trillion Dollars and Counting
- Virtually limitless demand versus finite resources
WHICH BEST DESCRIBES YOUR VIEW OF THE INDEPENDENT, PRIVATE PRACTICE MODEL?

- It is a dinosaur soon to go extinct: 28%
- It is on shaky ground: 58%
- It is relatively robust and viable: 14%
Imminent Physician Shortage

- 36 million baby boomers entering Medicare
- By 2025 AAMC forecasts a shortage of 130,000 physicians
Training

• Due to impending shortage of physicians medical school capacity has expanded dramatically
  • In 2002 there were 16,488 entering medical students and in 2015 there will be 20,181. A 22% increase
  • As well as a doubling of osteopathic class size from 3079 to 6222 in the same time period
  • Residency program funding was frozen in the Balanced Budget Act of 1997 so no increase in residency spots which limits specialty training (Erikson 2011)
Effects of Freeze on Residency Spots

• Scarcer resource should drive up market price

• This will lead to an increased reliance on mid-level providers

• However NPs are also scarce. The average age of NPs in the US was 50 in 2008.
Should We All Become Employed?
Why the growth of hospital based physicians?

Figure 1.5
HOSPITALS’ PHYSICIAN STRATEGY ISSUES

Survey of Hospital Administrators in 2009
Hospitals

Between 2003-2010 number of hospitalists has tripled and neuro-hospitalists have increased by 5 fold (AHA, 2011)

Hospitals with more than 100 beds have gone from 55% to 91% with hospitalists

In 2006 number of Physicians who submitted no hospitals bills was 38% (Fischer 2007)

Number of physicians who practice in hospital owned groups has doubled since 2003.

However most hospitals lose money on their physicians
## Performance of Hospital vs Non Hospital Multi Specialty Groups

<table>
<thead>
<tr>
<th></th>
<th>Best Non Hospital Group</th>
<th>Rest of Non-Hospital Groups</th>
<th>Best Hospital Group</th>
<th>Rest of Hospital Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overhead %</td>
<td>58.3</td>
<td>60.0</td>
<td>56.8</td>
<td>83.4</td>
</tr>
<tr>
<td>Gross charges per FTE</td>
<td>$1,372,247</td>
<td>$1,069,530</td>
<td>$995,303</td>
<td>$755,855</td>
</tr>
<tr>
<td>Physician RVU per FTEs</td>
<td>13,096</td>
<td>12,809</td>
<td>9,714</td>
<td>9,117</td>
</tr>
<tr>
<td>Total MD revenue per FTE</td>
<td>$351,082</td>
<td>$280,439</td>
<td>$261.865</td>
<td>$69,881</td>
</tr>
</tbody>
</table>

*MGMA, 2011* Does not take into account salary of physicians.
Hospitals

• Expenses for hospital owned physicians were 8% lower than non-hospital based

• Net collected revenues were $100,000 lower per FTE

• Compared to better performing practices revenue was 35% less (Advisory Board 1999)

• Median practice loss per FTE per year was $190,000 (Gans 2012)

• Now this does not take into account downstream revenue but…
For all the appearance of change..

- In 2008, 47% of Physicians were still in groups of five or fewer and 32% were in solo practice.
- In 2011 in metropolitan areas of 1 million or more 41% of physicians were in practices of five or fewer (Mckinsey 2012).
Does Size Matter

- In 2008, physician productivity declined as groups grew from one to eight.
- Incremental revenue growth was only apparent after groups were greater than 25 (Hough, Gans 2010).
- Greater administrative complexity is difficult to overcome.
- There were a few exceptions, notable orthopedics and anesthesia.
- However, these studies did not address the “market power” effect whereby single specialty groups could create a monopoly.
Good Management Matters

More

- Best performing groups have 7.5% lower overhead
- These groups out earned their peers by 26%
- And outworked their peers by 31% (based on RVUs) (Gans 2012)

Overhead, Overhead, Overhead
Fixing the Broken Model: Innovation Matters

- Over the past fifty years, while the environment of care has changed drastically… the clinical office has been remarkably stable in structure and function. The physical layout, the exam room, the scheduling system and visits as the mechanism of care are all virtually unchanged. Dr. Charles Kilo, Health Affairs, 2010
What are the Best Management Practices

- Flexible staffing for support staff
- Cross training staff for increased flexibility
- Intelligent use of mid-levels
- Rigorous tracking of accounts receivable (day of care payment of co-pays)
- Aggressive collections of patients owing balances on bills
- Cost sensitive procurement of supplies
- Sub-letting available space
- EHR coordination with coding and billing
Innovative Practice Models

• “Micropractices”
  • Leasing one exam room from another provider
  • Lean EHR system
  • Start up costs are $15,000
  • Easy access to physician
Innovative Practice Models

• Medical Home
  • Pilot project 5.6 FTE, 6 MAs, 2 LPNS, 1.5 PAs
  • Improved access and comprehensive care of patients
  • 29% reduction in ER visits
  • 6% fewer hospitalizations
  • Increased cost by $5.60 PMPM
  • Savings were $18.18 PMPM (Larson 2012)
  • Concept of global risk for chronically ill
Innovative Practice Models

• Concierge Medicine
  • Continuous contact with care team
  • Defined annual or monthly fee
  • Slow growth of this model based on consumer purchasing power
  • Single biggest source of bad debt in medical practices is not care to uninsured but care to insured who do not pay their portion
Innovative Practice Models

• The extensivist
  • Focused on care coordination for the patient with chronic illness
  • Connect multiple care providers
  • Develop protocols to keep patients out of ERs and hospitals
  • Dr Sheldon Zinberg in Los Angeles built 26 care sites for patients with GI issues
    • 18% lower costs than medicare averages
    • 24% reduction in hospitalizations
    • 38% shorter LOS inpatients
    • Because this was contracted with Medicare physicians were able to reap the benefits (Main and Slywotsky, 2011)
Innovative Practice Models

• Another example in Camden New Jersey, Dr Jeffrey Brenner (Gawande 2011)
  • Developed SWAT teams of physicians, nurses, social workers to address super-users
  • 1% of Camden population accounted for 30% of the community health care costs
  • The team leader is the extensivist
  • Cost was $1.2 million in ER visits per month (for 36 people). The program cut costs for ER by 40% and hospital charges by 50%
The Future

• Providers or hospitals or physicians will be asked to assume greater responsibility for managing the cost of health care

• Physicians need to be prepared to organize to bear some responsibility and also to be able to reap the financial rewards if successful

• How do we provide better comprehensive care for patients in a more cost effective way
How do you believe reform will affect the quality of care you are able to provide?
Changes Almost here

• Elimination of Medicare “Site of Service” differential
  • Higher reimbursement if services are provided in the hospital
    • Value of physicians work is 50-80% higher if performed in the hospital than in private practice
  • Med Pac has proposed eliminating this differential
  • If eliminated this will reduce enticement for hospitals to buy physician practices.
What can we do today to improve care and revenue

- Care Plan Oversight
- Chronic Care Management
- Integrate comprehensive services
  - Drug Dispensing
  - Ancillary service like PT/OT
  - Dementia care- in home services
  - Imaging
Care Plan Oversight

- G0181: “physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.”

- G0182 describes the same service for a patient in a Medicare-approved hospice.
## CARE PLAN OVERSIGHT REQUIREMENTS

- The physician cannot have a significant financial arrangement with the home health agency or hospice that is providing care to the patient.

- The physician may not be an employee or medical director of the home health agency or hospice.

- Only one physician per month may bill CPO.

- The physician who bills for the CPO must be the same physician who signed the certification for the home health agency or hospice in the first place.

- The physician must have had a face-to-face service with the patient within six months of billing for the CPO.

- The physician must have personally provided at least 30 minutes of service in one calendar month.
Care Plan Reimbursement

- G0181 reimburse $50.20.
- At only 50 patients per month that leads to $30,000 per year.
- How many of those plans do you sign per week?
Care Plan Oversight

• Apparently, growing numbers of physicians have been sorting through CPO's complexities. CMS has noted a significant increase in the payments to physicians for CPO, from $15 million in 2000 to $41 million in 2011. As a result, billing for CPO is an area that the OIG has announced it will be scrutinizing more carefully this year for evidence of fraud.

• Don't let this scare you. If you meet the requirements, you should bill for these services.
Chronic Care Management

• Separate payment for CPT code 99490 for non face to face management/coordination
• Beneficiaries with 2 or more chronic conditions
• Only one practitioner can bill for CCM per month
• This is already in effect and is $43/month
Chronic Care Management

- $43/month per patient
  - If you see 1000 new patients per year. If 20% are medicare
    - 200 patients times $43 times 12 months equals $103,000 a year.
  - Even if only half the patient agree to enroll that’s roughly $50,000 a year per doctor
CCM: Scope of Service

- Structured recording of demographics, problem list, medications, allergies and has to be in an HER
- 24/7 access to care management services
- Continuity of care with one provider
- Systematic Assessment of health needs
- Electronic Care Plan (There may be new technology for this coming)
- Managing care transitions between health care providers (Transmitting reports electronically and not by fax)
- Coordination of home based therapies when appropriate
- Informed Consent
Who can furnish CCM

- MD, PA, NP, RN, and clinical staff incident to these practitioners
- So your front office staff can do all the work here and have them document in patients chart at the end of each month and generate the bill for you
- This is in essence paying for one full time employee without doing any additional work
Conclusions

• Diverse practice models are needed to match diverse needs and resource position of consumers

• Physicians should strive to diversify their practice offerings and find market and clinical niches

• Fostering experimentation with new care models is vital to preserving the vitality of physician practice

• There are ways to have your cake and eat it to. Strive to provide the best possible care and be sure you use every method available to get reimbursed for the work you do.