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PRACTICE MANAGEMENT

Why private practice isn't dead – it's making a comeback

Many people of a "certain age" fondly recollect their close personal relationship with their pediatrician, family or internal medicine doctor. The physician was often considered to be like an extended member of the family who not only provided great health care but also was an esteemed member of the community and friend. Are these memories of "Marcus Welby, M.D." a thing of the past?

Prior to the 1990s over 85% of physicians in the United States were in private practice. Private practice is defined as a practice owned by the majority of physicians who practice in the office. By 2000, the figure fell to 60% and by 2005 it was down to 50%. As of 2016, only 33% of physicians were estimated to be in private practice.

What happened?

Over the years, reimbursement from third-party payers has steadily declined. Many commercial insurance companies now reimburse around the same rate as Medicare. At the same time, physician overhead has dramatically increased due to such factors as increased malpractice cost, technology costs, and employee wages. In the "good old days," most any medical practice could operate profitably, even if their business operation was inefficient. In the current environment, only efficient, lean and well-managed practices tend to survive.

Hospitals must have physicians to care for patients. Without physicians, the entire healthcare system would collapse. As private practices failed or became less profitable, hospitals saw a need and opportunity to begin buying practices and employing doctors. What appeared to be a can't-lose proposition became a nightmare for many hospitals. Hospitals discovered that managing a medical office was very different than running a hospital.

On average, most hospitals lose from $100,000 to $150,000 each year per doctor they employ. But hospitals must have physicians to operate, as

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they keep reminding themselves.

R. Earl Conkin, CHBC, EA, is a healthcare business consultant with 40 years experience in the industry. "We have seen two or three cycles of hospitals buying practices and then selling them a few years later due to financial losses," Conkin says. "While this trend has slowed in recent years, owning practices is still not the right strategy for all hospitals."

What can we expect from the future?

It is likely that the majority of new physicians will continue to be employed by healthcare systems or by large, for-profit medical groups. But private practice is alive and well and increasing numbers of old and young doctors will remain in or even shift to private practice. The reasons are varied:

- **Flexibility and freedom.** Physicians are trained to think for themselves and act decisively. These traits are needed for good clinical care. Hospitals and large groups, instead, expect conformity and fitting into an established system. A growing numbers of physicians, especially those formerly in private practice, want the flexibility and freedom only a private practice can offer.
- **Respect.** Physicians work long and hard for their credentials and the right to be called "doctor." Many hospitals and large healthcare groups treat physicians just like any other worker in the system. One doctor observes, "After years in private practice, I felt I had earned a certain amount of respect. Now I seem to be treated no differently than a secretary or the janitor, despite my training and experience." Private practice offers a return to respect for many physicians.
- **New practice models.**
  - ◊ **"Pay as you go."** In this type of practice, reasonable cash prices are charged for all services. No insurance is filed. The physician really gets to know his patients and spends a much longer time in visits with them as compared to most traditional practices. As copayments and deductibles soar, and some remain uninsured, many patients find a $75 fee for a visit quite reasonable. Some patients equate this model of care as going "back to the future" and find it highly satisfying. Frederick Martin, MD, a family physician in Bristol, Tenn., has practiced under this model for about four years. "When I was in a traditional practice, I spent much of my time on insurance-driven documentation and communication," he says. "Now I can devote more time to actual patient care. My patients and I are much happier."
  - ◊ **Concierge medicine.** This model provides comprehensive care in exchange for payment of an annual retainer. Some practices may also have per visit charges or, in some cases, also bill insurance. These practices usually have small patient bases and often guarantee same-day appointments as well as the ability to communicate directly with the physicians by email or cell phone. These practices have become more popular among upper middle class and affluent patients as physician shortages have developed.
- **Other alternative models.** New models of care delivery are developing rapidly to address changing needs and technology.
  - ◊ **Internet medicine.** Under this model, patients with a minor illness or who simply need a prescription refill can sign into a website and skip the office visit while paying a very reasonable fee.

- **Mid-level provider practices.** Most states allow nurse practitioners and physician assistants to either practice independently or under some level of physician supervision. Some patients find it easier or less intimidating to speak with a non-physician practitioner and the costs and wait times are usually lower.
- **House call practices.** Want to avoid a trip to the urgent care or emergency room and be treated in the comfort of your home? If so, many areas now offer one or more practices that provide house calls just like the old-timey physician.

What can we expect from the future?

Times change and so do expectations for healthcare delivery and outcomes. But in the end, patients will continue to get sick and need care, and physicians will continue to provide this care no matter the challenges that arise. Many physicians will continue to be employed by hospitals or large groups. But an increasing number of doctors will return to private practice. Just like "mom and pop" restaurants that often thrive amidst slick, well-funded chain restaurants, select private medical practices can and will coexist with hospital employed and large group practices. Ours is a culture of choice and competition. Private medical practices will ensure this balance continues to exist.

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CONGRESSIONAL ACTION

Practices, patients face uncertainty after repeal failure

The Republican effort to repeal the Affordable Care Act (ACA) has ended with no change to the status quo, and there appears to be no concrete plan to restart the legislative effort for the time being. Rising premiums for individual coverage and the possibility that Republicans could still defund the ACA without passing a repeal bill leaves providers and patients in limbo, practice sources tell *The Business of Medicine*.

"Write-offs have been lower since the ACA, and the Medicaid expansion has really helped out big time in terms of more patients and more payments for those patients who were previously write-offs," says Kristine McGriff, COPM, MPA:HA, administrator for the Department of Otolaryngology Head and Neck Surgery at Oregon Health & Science University.

The write-off amount for the ENT department went from nearly $800,000 in 2010 – the year the ACA took effect – to $322,000 at the end of 2016, McGriff says. The ACA's Medicaid expansion has driven this change, resulting in more patients presenting for more routine care, and for getting "something back instead of nothing" for providing those services, McGriff says.

Practices look to contain costs

Now, with the repeal effort stalled and Republicans divided over how to proceed, McGriff's group is carrying on cautiously. After it became apparent that Republicans would be able to repeal the ACA, her department put cost-containment plans into effect to mitigate the impacts of an eventual repeal. That means limits on new hires, new spending, and new initiatives, McGriff says.

Her system is also bracing for a return to a clinical workflow that involves much sicker patients, she says. Prior to the ACA taking effect, poorer patients tended to avoid regular office visits and only show up to the emergency room when their ENT complaints became too serious to ignore. "Before, some people were not coming in until the mass in their neck was so large that they were having trouble breathing, so that they had to come into the ER," McGriff says.

With the increased coverage from the ACA, such patients have instead been able to come in with smaller lumps that could be biopsied and treated in their outpatient clinics.

Trump's mixed messages on repeal's future

Since Republicans withdrew their ACA replacement bill, President Donald J. Trump has sent conflicting signals over whether he would pursue the repeal in the short term, and if so, how aggressively. Initially, Trump stated that his legislative priorities would shift to tax reform and that Republicans had squandered their best chance to repeal the ACA, even as he also predicted that the law would fail on its own.

Having seen the fate of a repeal bill without any Democratic support, the White House appears to be maneuvering to provoke a response from Democrats. In an April 12 interview with *The Wall Street Journal*, President Trump suggested that his administration may not continue paying the subsidies that lower-income Americans rely on to maintain insurance coverage. If and when that occurs, Democrats would be wise to seek negotiations on a repeal bill, Mr. Trump said.

The issue will reach a boiling point at the end of April, when Congress must act to keep the subsidy cash flowing or risk a mass exodus of the remaining insurers who offer ACA plans. The Congressional Budget Office (CBO) has estimated that the subsidies would cost the federal government approximately $135 billion from 2018 to 2027.

For their part, Democrats have refused to offer any signs of compromising. "President Trump is threatening to hold hostage health care for millions of Americans, many of whom voted for him, to achieve a political goal of repeal that would take health care away from millions more," said Senate Minority Leader Chuck Schumer (D-NY), in a statement.

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HUMAN RESOURCES

Using E-Verify to check immigration status

With immigration enforcement issues all over the news, this is a good time to revisit one of the main tools employers have to ensure that their workers are documented and legal: E-Verify.

Authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), the E-Verify Program is an Internet-based program run by the Department of Homeland Security (DHS) in partnership with the Social Security Administration. Its purpose is to ensure a legal workforce, protect jobs for authorized workers, deter document and identity fraud, and work seamlessly with Form I-9.

Nearly 700,000 employers currently use E-Verify. It is required for most federal contractors and many employers are required to use E-Verify through an ever-expanding web of state requirements. Businesses input information reported on a new hire's Employment Eligibility Verification Form I-9 to the Department of Homeland Security (DHS) through the E-Verify system, which uses Social Security Administration data to determine legal status.

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In 2012, eight states enacted legislation related to E-Verify: Alabama, Georgia, Louisiana, Michigan, New Hampshire, Pennsylvania, South Carolina, and West Virginia.

Three of these states now mandate E-Verify for at least some employers: Michigan, Pennsylvania, and West Virginia. Other states made technical changes to earlier laws, clarifying definitions, creating safe harbor provisions or establishing a hotline to report work authorization violations.

As of November 30, 2012, a total of 20 states require the use of E-Verify for at least some public and/or private employers: Alabama, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, and West Virginia.

Eighteen of these requirements were through legislation and in two statesFlorida and Idaho, by executive orders. Two states, California and Illinois, currently limit the use of E-Verify. Other states are exploring alternatives to E-Verify or identifying safe harbor provisions. North Dakota is the only state to mandate a Legislative Management study on the feasibility of mandating the use of E-Verify.

View E-Verify requirements by state at www.numbersusa.com/resource-article/everify-state-map. "E-Verify is

CMS releases final rule on ACA market stabilization

The 60-day freeze on new federal rulemaking ended on March 31, and CMS has released a final version of its rule aimed at stabilizing the individual marketplace established under the Affordable Care Act (ACA).

The Market Stabilization final rule is one of the first issued under Seema Verma, the new CMS Administrator selected by President Donald J. Trump. The rule, which originally appeared in proposed form in early February, is intended to stem the tide of insurers fleeing the ACA's individual market. Uncertainty over the future of the ACA's federal subsidies, which are income-based and offer greater support to the lowest-income individuals, has caused many insurers to leave. Here are the highlights from the CMS final rule:

- **Revised dates for ACA plans' 2018 enrollment period.** The final rule adjusts the annual open enrollment period for 2018 to match Medicare's schedule and the schedule of most commercial payers. The next open enrollment period will start on Nov. 1 and run through Dec. 15, dates which will encourage individuals to enroll before the beginning of 2018.
- **Tighter enrollment rules.** Individuals must now submit additional documentation to be eligible for special enrollment periods (e.g., proof of childbirth or adoption). This move is also intended to incentivize individuals to stay enrolled year-round, reducing gaps in coverage and resulting in fewer individual mandate penalties and lower premiums overall.
- **Past-due payments required.** Individuals who owe past-due premiums must first pay the due premiums before they will be allowed to enroll in a new plan or reenroll with the same insurer the following year. This is another measure intended to promote continuous coverage and lower premiums by keeping payments steady for insurers.
- **More flexibility for insurers.** Starting in 2018, the final rule allows insurance companies more flexibility to offer plans with lower premiums and fewer benefits, a move that will benefit younger, healthier individuals.
- **Feds will no longer review network adequacy.** The final rule no longer requires that the federal government conduct reviews of insurers' provider networks to ensure they have adequate coverage in terms of physician access and access to specialties. The final rule calls the federal reviews "duplicative" and a waste of taxpayer money. Individual states will now have the final say over provider network adequacy.

The final rule does not address the issue of federal subsidies, which will be cut off at the end of April without Congressional action to keep the cash flowing.

a proven tool for employers that helps reduce incentives for illegal immigration and safeguards job opportunities for Americans and other legal workers," said Sen. Charles Grassley, R-Iowa. "Expanding the system to every workplace will improve accountability for all businesses and take an important step toward putting American workers first."

The program has been reauthorized several times and is set to expire on April 28, 2017.

Recent legislation has been reintroduced that would permanently authorize and require all employers to use the E-Verify program as it is becoming the not-so-voluntary system of choice. The recent legislation would:

- Permanently reauthorize the E-Verify program.
- Make the program mandatory for all employers within one year of enactment; require federal contractors and agencies to use the program immediately; and direct "critical employers," as identified by DHS, to use the system within 30 days.
- Increase penalties for employers that illegally hire undocumented workers.
- Reduce the liability that employers face if they wrongfully terminate a worker due to inaccurate information provided by E-Verify.
- Allow employers to use E-Verify before a person is hired if the candidate provides consent.
- Require employers to check the status of all employees not previously verified through E-Verify within three years of enactment.
- Require employers to terminate employees found to be unauthorized to work due to a check through E-Verify.
- Require employers to reverify an employee's immigration status if the employment authorization is due to expire.

While not all pundits expect comprehensive immigration reform this year, Congress is very likely to pursue more targeted approaches on legislation, including interior enforcement extending to the implementation of a mandatory, nationwide E-Verify program.

Absent congressional action, additional states and localities could enact measures to require E-Verify as part of the employment verification process. It is conceivable, however, that a mandatory EVerify program will garner support in this Congress, as it may have its best chance for passage in years with Republican majorities in both houses of Congress

New DoctorsManagement clients

Client	Services provided
Plastic surgery group, GA	Practice merger and acquisition
Solo practitioner, CO	Feasibility study
Solo practitioner, NY	Practice assessment
Dermatology practice, AZ	Practice assessment
Eye group, TN	Practice manager search
Clinic group, KY	Compliance assessment
Neurosurgery practice, GA	Procedure coding
Urgent care group, GA	Coding audit
ENT group, IL	Annual coding audit
Foot and ankle specialists, GA	On-site coding training
Management group, NY	Coding compliance training materials
ENT practice, OR	Monthly accounting
Pediatric and family practice, TN	OSHA manual
Pediatric group, TN	CLIA consulting
Family practice, OK	Employee OSHA training
Orthopedic clinic, TN	Credentialing training

and President Donald Trump's pledge to strictly enforce immigration laws.

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CODING AND COMPLIANCE

New rule in effect: You must use modifier JW for discarded drugs

All physician practices, regardless of their location or Medicare Administrative Contractor (MAC), should have begun appending **modifier JW** (drug amount discarded/not administered to any patient) to drug supply codes as of Jan. 1, 2017. Appending the modifier will get you paid for the portion of an injected drug or biologic that was not administered to a patient.

This rule has been long in coming: It was first detailed last April in Transmittal 3058 to the Medicare Claims Processing Manual, and was set to become effective last July. However, the rule was delayed until this year and officially became effective on Jan. 1, 2017. Previously, some Medicare contractors (MACs) required JW to be used, but CMS issued the transmittal to standardized billing and accountability for discarded drugs across Medicare. The agency has steadily made progress toward standardization on a variety of multi-specialty issues to avoid the sometimes untidy maze of MAC-specific requirements.

How to bill for discarded drugs

Your providers are now required to attach **modifier JW** (drug amount discarded/not administered to any patient) to the J-code for any drug that is not actually administered *except* when the drug is acquired as part of a competitive acquisition program (CAP).

When there are discarded drugs or biologics, this means the claim for the drug must have two lines just for the drug. One line should include the code for the drug and the amount that was administered to the patient. The second claim line should include the same code, the amount of the drug that was not administered to the patient, and the JW modifier.

Medicare will pay for the unused portion of the drug at the same rate as the amount that was actually administered.

In addition, and this is a critical point for the provider who actually administers the drug and documents the administration, the amount of the drug that is not administered during the visit **must also be documented in the patient's medical record** for that encounter.

The practice would not use the JW modifier on a separate claim line in an instance where the billing unit represented by the code is the full amount of the drug that is in the single use vial or container.

Review: Clinical examples

Let's consider an example of a drug where a single-use vial contains 10 mg and one unit of the HCPCS code for the drug is equal to 10 mg. In this scenario, the provider would bill only for one unit of the HCPCS code, regardless of whether any was discarded.

Suppose 7 mg of the drug was administered and the other 3 mg was discarded. If the provider were to bill a second

claim line for the discarded drug with the JW modifier, in this instance, it would result in an overpayment if the MAC paid both lines of the claim, because each payment would be for 10 mg of the drug, or 20 mg, when only 10 mg was actually used during the encounter.

Even in these situations, we recommend that your provider document how the drug was used, both the amount administered to the patient and the amount discarded. The only difference would be that only one unit of the appropriate J-code would be billed.

MACs will typically pay the claims based on how the JW modifier is being used on the claim itself, but a MAC audit that uncovers the drug wastage not being properly documented in the medical record could result in a substantial repayment demand, especially given the high per-unit prices of many injectable drugs.

Note: For some providers, their MAC already has these relatively strict requirements in place, so they won't face any change. Many others will need to adapt.

Note: Multi-use vials are not subject to the JW modifier usage policy or to payment for any wastage, as it's expected that the drug would be used on subsequent encounters with the same patient or a different patient.

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