Concierge Medicine

Carolyn R. Wolf, Esq.
Nassau County Bar Association Conference
May 19th, 2010
Definition of Concierge Medicine

• A relationship with a primary care physician where a patient pays an annual fee or retainer
• Membership fees range, in most cases, from $500 to $4000 annually
• Patients typically receive 24/7 access to a personal physician’s cell phone, same day appointments with no waiting period, personal coordination of care with specialists, house calls, etc.
• Estimates suggest that there are between 400 and 5,000 concierge care physicians in America
• Concierge medicine is not insurance – it focuses, instead, on a “proactive, preventive” approach to health care
History of Concierge Medicine

- Originated with a medical practice in Seattle, WA., in 1996
- Physicians in this practice provided comprehensive primary care to no more than 100 patients each, and charged annual retainer fees of $13,000 per individual in 2005. These physicians did not bill any form of patient insurance plans.
- As concierge medicine developed, concierge care diversified; doctors began billing patient insurance plans, charged lower membership fees, and started seeing more patients as well.
Services Offered by Concierge Care Physicians

- Same or next-day appointments for non-urgent care
- 24-hour telephone access
- Periodic preventive-care physical exams
- Extended office visits and private waiting rooms
- Access to physician via email and cell phone
- Wellness and nutrition planning
- Coordination of medical needs during travel
- Home visits
- Smoking cessation support
- Newsletters
- Mental health counseling
Emergence of Private Pay Arrangements in the Era of Managed Care

- Widespread dissatisfaction with managed care
- Physicians argue that managed care doesn’t allow sufficient time to properly diagnose patients
- Patients claim that managed care doesn’t allow them time to fully discuss their concerns with their doctors
- Doctors and patients generally have insufficient time to form a relationship
- Within this context, concierge medicine has emerged as an attractive alternative
Factors Favoring Concierge Medicine

- It is very attractive for doctors
  - Concierge physicians typically care for fewer patients than doctors in conventional practices
  - Physicians are able to know their patients better and become their health partners
    - “The doctor’s office becomes the patient’s comfortable, easily accessible medical home, instead of a hurried place full of other sick people and doctors who have no time to spare”
- ER visits and hospitalization generally decrease substantially
- Higher earnings – some concierge care physicians reported earning on average $1 million annually
Medical, Legal and Ethical Issues Involved in Concierge Medicine

- Compliance with Medicare
- Access to health care
- Undue pressure on patients to agree to a retainer arrangement
- Overuse of medical services
- Violation of state health insurance laws
- Violation of state anti-discrimination statutes
Where Do We Go From Here?

- The AMA has not specifically condemned concierge medicine, but has taken the position that these practices cannot claim to provide higher quality diagnostic and treatment services than traditional practices.
- The AMA does not believe that concierge care will expand significantly, and claims that it doesn’t depart from the already multi-tiered system of health care in America.
- Some experts suggest that concierge medicine may be a waning fad. There are difficulties in starting a concierge care practice, with high upfront costs, and little income until a few hundred patients sign up and start paying their retainers.
CONCLUSION
Consolidation and Restructuring of Traditional Physician Practice Models

David A. Zarett, Esq., Partner
Weiss & Zarett, P.C.
3333 New Hyde Park Road, Suite 211
New Hyde Park, NY 11042
Tel: (516) 627-7000
Fax: (516) 877-1172
Hospital Relationships with Physician Groups:

Competition or Cooperation?
I. Competition

- Economic Credentialing
- “Closing” Departments
- “Conflict of Interest” Bylaws
- Pretextual Quality Assurance
Statutes

- Public Health Law Section 2801-b
- Public Health Law Section 206-a
- Federal Antitrust Statutes, Sherman Act Section 1 and 2
- Health Care Quality Improvement Act
Cases

- *Odrich v. Columbia*: Financial Demands
- *Gelbfish v. Maimonides*: Exclusive Contracts
- *Lipzstein v. Mount Sinai*: Reapplying Upon Change of Full-Time Status
- *Reddy v. Puma*: Antitrust Claim Pre-Twombley
II. Cooperation: Acquisitions of Groups

- Control/Autonomy
- Job Security
- Valuation/Compliance
- Non-Competition Covenants
- Compensation/Benefits
- Faculty Practice Plans
- “Unwinding” Concerns
New Managed Care Reform Law: A Win for Physicians and Hospitals

Claudia A. Hinrichsen, Esq.
Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP
chinrichsen@abramslaw.com
516-368-9499
May 19, 2009
Agenda

Overview of the New Managed Care Reform Act of 2009:

- Health Plans to Pay More Promptly
- No Payment Delay in COB Situations
- Extension of Time for Claim Submission
- Protection from Retro-Audits
- Provisional Credentialing for Physicians
- Notice of Reimbursement Changes to Managed Care Contract
Health Plans to Pay More Promptly

New managed care law amends the 45-day claim payment requirement of New York’s current Prompt Pay Law.

• Effective January 1, 2010, health plans required to pay electronically submitted claims within 30 days of submission, except when liability is not reasonably clear. Interest accrues after 30 days.

• Health plans will continue to pay paper or faxed claims within 45 days.
Health Plans to Pay More Promptly, cont.

- For disputed claims, where the obligations of the health plan are not “reasonably clear”-
The health plan must pay the undisputed portion within 30 days of claim receipt and must notify the provider that it is not liable to pay disputed portion, and must cite specific reasons for why it is not obligated to make additional payment.

- Alternatively, health plan must request additional information to determine liability to pay claim.
A new section was added to the law -

A health plan prohibited from denying payment on claim, in whole or in part, on basis that it is coordinating benefits with other potentially liable payors, unless the health plan has “reasonable basis to believe that the Insured has other health insurance coverage which is primary for that benefit.”

Where plan does not have info, plan can seek info. If info not received timely, claim must be adjudicated.

Plan can not hold back coverage more than 45 days waiting for enrollee to return requested information.
Did the New Law Go Far Enough to Ensure Timely Payment By Health Plans???

Penalties Inadequate to Dissuade Wealth Health Plans. In 2008, only $280,000 in penalties were assessed under the Prompt Pay Law. (NYS Ins. Report of the Superintendent at p. 150).

Nonetheless, providers should report Prompt Pay Law violations to the Dept. of Insurance. Squeaky wheel gets the grease.
Extension of Time for Claim Submission

- Before new law, health plans generally would mandate claim submission within 60/90 days.

- Under the new law, health plans must pay claims when submitted within 120 days of date of service.

- The 120 day time-frame can be extended by contract.
Extension of Time for Claim Submission, cont.

- If a Provider can prove that a claim was submitted more than 120 days after service date due to “unusual occurrence,” Plan will be required to pay minimum of 75% of Provider’s claim to the extent provider has a “pattern or practice of timely” submission.

- Parties can negotiate reduction of less than 25% in the managed care participation agreement.
Health Plans to Pay More Promptly, cont.

Gaps in the New Law:

- New Law does not define what constitutes an “unusual occurrence” or “pattern or practice of timely submission.”
- Parties could include their own definition in managed care contract.
Protection In Cases of Retro-Audits

- Health plans must provide 30 days’ advance written notice of any demand for repayment and the reason for the demand.
- Health plans must establish written policies and procedures that will be followed where provider wants to challenge overpay recovery. This includes plan sharing of claim info.
Hospital Protection from Retro-Audits, cont.

Contract Negotiations after the Managed Care Reform Act-

- Providers can seek even tighter limits for retro-audit-
  - 2 years is a long time.
Provisional Credentialing

- In the past, physician practices have been frustrated waiting for health plan to credential a new member of the practice.
- Under the new law, if the health plan fails to act on the credentialing application within 90 days, physician will be deemed “provisionally credentialed” after joining a group where all practitioners are participating with a plan and the physician is a new practicing physician or has relocated from another state.
- The group practice must make certain written representations to the plan to take advantage of the provisional credentialing status.
- The health plans need to process credentialing applications within 90 days.
Provisional Credentialing, cont.

Gaps in the new law:

- Not all providers in the group practice may be par with a plan. The new law will not help in such circumstances.
Notice of Reimbursement Changes to Managed Care Contract with Physicians

• Health plans no longer will be able to unilaterally institute silent changes to the reimbursement structure of managed care contracts with physicians.

• Under new law, an insurance company can not unilaterally implement an adverse reimbursement changed to a managed care contract with a physician without 90 days’ written notice.
Notice of Reimbursement Changes to Managed Care Contract with Physicians, cont.

- The physician will have the right to notify the managed care company that physician wants to terminate the contract upon the effective date of the reimbursement change.
- For purposes of the new law, “Adverse Reimbursement Change” means a change that could be expected to have a material adverse impact on the aggregate level of payment under the contract.
Merging Physician Practices
Moving Toward “Megagroups” and Multi-Specialty Practices

Joel M. Greenberg, Esq., Partner
Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger
1111 Marcus Ave, Suite 107
Lake Success, NY 11042
Tel: (516) 775-0042
jgreenberg@abramslaw.com
Reasons

- Negotiating leverage with payors
- Operational efficiency and sharing overhead
- Capture service revenues otherwise sent out the door
- Conduct diagnostic testing in-house
- Additional sources of investment capital for diagnostic testing equipment, office space, marketing and EMR
- Better working hours, less administrative responsibility
Legal Considerations

- Antitrust
- Federal and State “Stark” Laws
- Federal Anti-Kickback Law
The Wrong Way

A “Loose Confederation”
of
Independent Practitioners
The Right Way

- Single entity and Tax ID
- Centralized management
- Common benefits

Not a “Group without walls”
Centralized Management

Organization-Wide Control:
- Budgeting
- Negotiating and contracting
- Credentialing
- Supplies acquisition and management
- Billing and collections
- Staffing
- Legal/Accounting
- Office leasing
- Marketing
The Back-Up Plan

Before You Leap:
1st Know How You Can Get Out!
Establish Rights Up-Front

Up-front Agreement:

- Withdrawal option (honeymoon period)
- Exclude current practice locations from restrictive covenant clause
- Exclude pre-existing patients, referral sources and employees from non-solicitation clause
- Reassignment of office lease, patient records, phone number, equipment and other practice assets
- Option to reduce work hours to part-time
The Intra-Divisional Agreement
The Intra-Divisional Agreement

Agreement provides for site-specific management authority (as consented to by centralized management committee), including:

- Hiring and firing staff, Approving physician assignments to your office
- Establishing work hours, vacation and call-schedules
- Internal revenue distribution based on productivity formulas
- Site-specific marketing
- Internal “buy-outs”
- How the decision to withdraw from the central organization is made
- More restrictive non-compete covenants
What are “Designated Health Services” (DHS)

(1) Clinical laboratory services.
(2) Physical therapy, occupational therapy, and speech-language pathology services.
(3) Radiology and certain other imaging services.
(4) Radiation therapy services and supplies.
(5) Durable medical equipment and supplies.
(6) Parenteral and enteral nutrients, equipment, and supplies.
(7) Prosthetics, orthotics, and prosthetic devices and supplies.
(8) Home health services.
(9) Outpatient prescription drugs.
(10) Inpatient and outpatient hospital services.

Means only DHS payable, in whole or in part, by Medicare.
Distributing DHS Revenues

- Equally across individual physicians
- In proportion to Non-DHS productivity
Unwinding Prior Practice (Or Not)

Maintaining original entity to:
- Collect accounts receivable
- Hold disability buyout and/or life insurance policies
- Enforce non-competition covenants against departing physicians
- In the event of withdrawal from the central organization (prior agreements kick back in)
The Basics of Recovery Audit Contractors

Nassau County Bar Association
CLE/CME Conference

May 19, 2010

Jennifer Kirschenbaum, Esq.
Kirschenbaum & Kirschenbaum, P.C.
200 Garden City Plaza
Garden City, NY 11530
(516) 747-6700
www.Kirschenbaumesq.com
Medicare Audit Initiatives

- CMS announced in February 2008 that $371.5 million in improper Medicare payments was collected from or repaid to health care providers and suppliers as part of the Recovery Audit Contractor demonstration program (RAC program).
- The RAC program is required to expand to all 50 states by 2010.
- NY’s RAC program is already in effect.
Authorizing RACs

- Medicare Modernization Act, Section 306: required 3-year RAC demonstration
- Tax Relief and Healthcare Act of 2006, Section 302: requires a permanent and nationwide RAC program by no later than 2010

Both statutes gave CMS the authority to pay RACs on a contingency fee basis
RAC Purpose

The RAC Program’s mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.
Limiting Medical Record Requests

Statement of Work states - The number of medical records in the request may not negatively impact the provider’s ability to provide care.
RAC Review Process: What do RACs look for?

- RACs review claims on a post-payment basis for:
  - Incorrect payment amounts
  - Non-covered services (including services that are not reasonable and necessary)
  - Incorrectly coded services
  - Duplicate services

- RAC review criteria follow Medicare policies: NCDs, LCDs & CMS manuals
RAC Review Process: Look Back Period

- Look Back Period:
  - RACs will NOT be able to review claims paid prior to October 1, 2007
  - RACs will be able to look back three years from the date the claim was paid
RAC Review Process: RAC Auditors and Oversight

RACs are required to employ a staff consisting of nurses, therapists, certified coders & a physician CMD.
Types of Reviews: Automated Reviews

- RACs use proprietary techniques to identify claims that clearly contained errors resulting in improper payments and those that likely contained errors resulting in improper payments.

- In the case of a clear improper payment, the provider is contacted and an overpayment is requested or the underpayment paid.
Types of Reviews: Complex Reviews

- Medical record review process
- Much more involved
- Clinical staff will review records
- Can request education from the RACs

Medical Director
Refund Request

Provider will receive a demand letter detailing any overpayment amount with a request for repayment.
Medicare Appeal Rights

- Redetermination: Request must be made within 120 days of initial determination
- Reconsideration: Request must be made within 180 days of redetermination – review by Qualified Independent Contractor (All new evidence must be submitted early and good cause shown why not presented prior)
- Administrative Law Judge: Request must be filed within 60 days following receipt of QIC decision
- Medicare Appeals Council Review: Request must be filed within 60 days following ALJ’s decision
- Federal District Court: Request must be filed within 60 days of MAC’s decision

Interest shall continue to accrue, from the date of the demand letter, throughout the appeals process.
Mitigating Damages

- Hire Healthcare Attorney upon receipt of request to control flow of information
- Bring in external coding expert for independent review of medical records
- Appeal findings you believe are incorrect
- Negotiate where possible
- Adopt or encourage clients to adopt a Compliance Program to help identify potential red flags, and govern billing and coding practices
Biography

Jennifer Kirschenbaum is a healthcare attorney specializing in Medicare, Medicaid and TTP audit defense. Her practice also includes drafting practitioner contracts (employment, partnership, management, etc.), licensure defense and regulatory compliance reviews for Stark and Anti-kickback violations.

Jennifer Kirschenbaum may be contacted at (516) 747-6700, ext. 308 or at Jennifer@kirschenbaumesq.com

For additional articles and information visit www.kirschenbaumesq.com