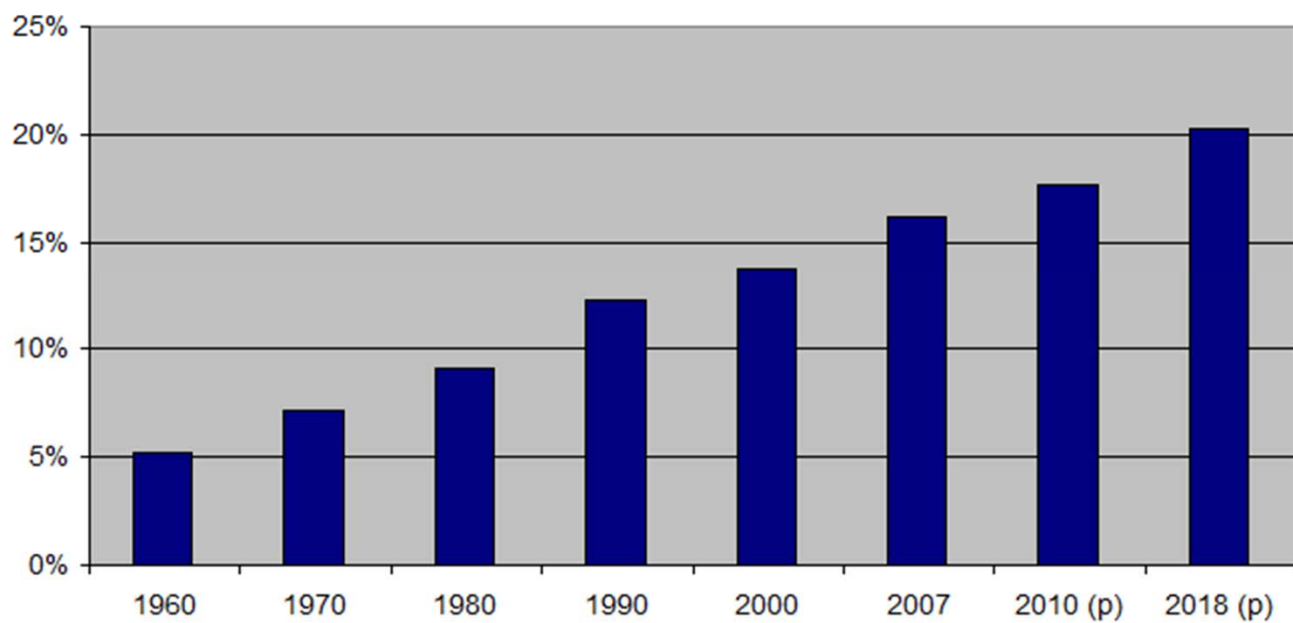


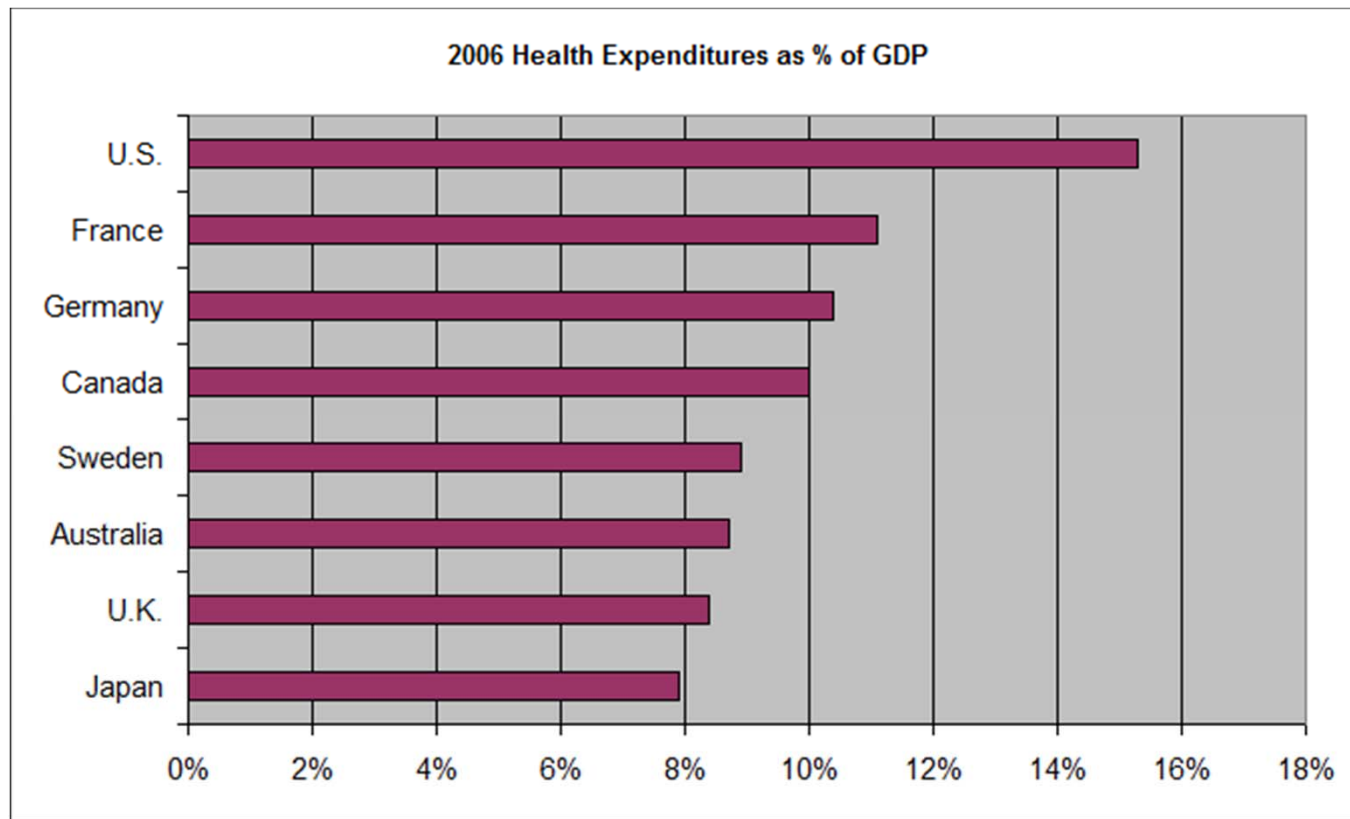
PHYSICIAN FINANCE

Where are we now?

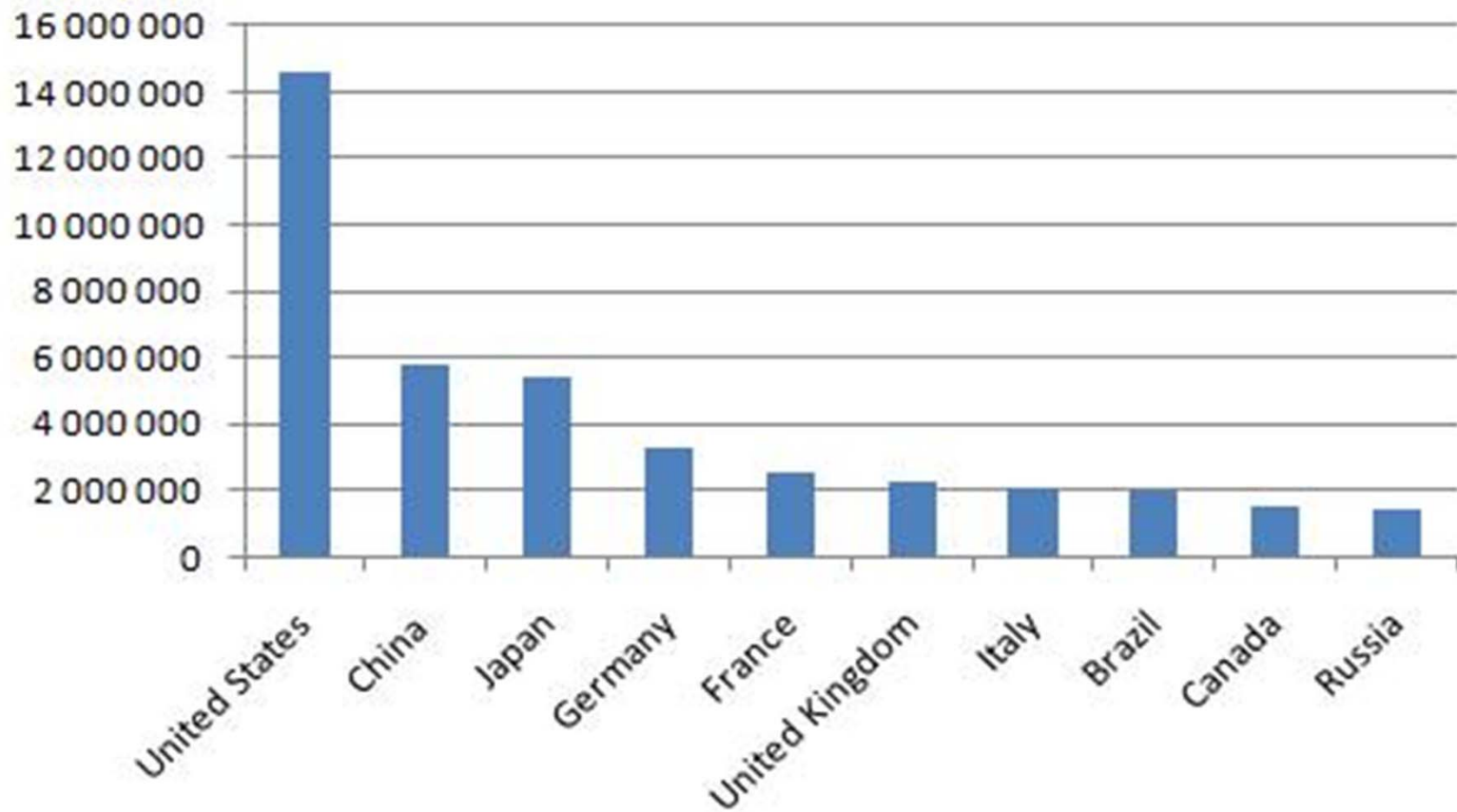
U.S. Health Care Expenditures as a % of GDP

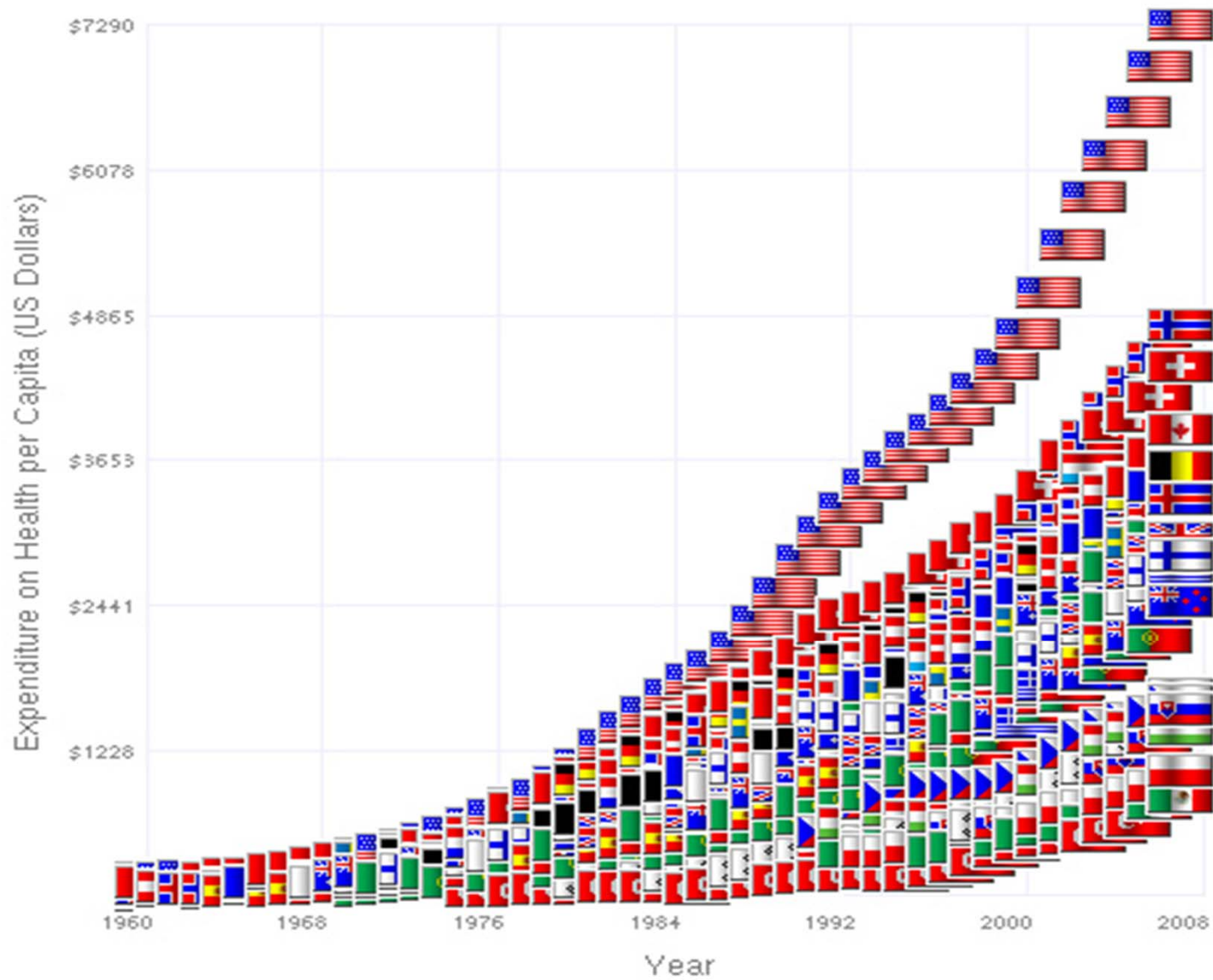


Healthcare Expenditures as a % of GDP



The ten largest economies in the world in 2010, measured in nominal GDP (millions of USD), according to the [International Monetary Fund](#)





Doctors are seeking employment

“Hospitals are now on a buying spree of private physician practices in the rush to build something that will qualify as an accountable care organization”

- Some 65 percent of doctors who changed jobs in 2009 moved into a hospital-owned practice,
- While 49 percent of doctors out of residency were hired by hospitals.

Some of the top 10 most challenging issues by Physicians

1. Dealing with rising operating costs, 73%
2. Managing finances with the uncertainty of Medicare reimbursement rates, 70.4%
3. Maintaining physician compensation levels, 54%
4. Collecting from Self-pay, high deductible health plans 52.3%
5. Negotiating contracts with payers, 50.5%
6. Modifying physician compensation methodology, 47.4%

Physician Reimbursement

What is “RBRVS”?

Resource based relative value scale

- (RBRVS) is a [schema](#) used to determine how much money medical providers should be paid. It is currently used by [Medicare](#) in the [United States](#) and by nearly all [Health maintenance organizations](#) (HMOs).
- RBRVS is the source for RVUs

What are RVU's?

- **Work RVU's:**
 - Physician component to value salary and benefits
- **Practice RVU's:**
 - Office expenses including depreciation, rent, office supplies, support staff and benefits
- **Malpractice RVU's:**
 - Both practice and physician insurance

Why do we care?

- Work RVU's are widely accepted and most common measure of clinician production (other than visits).
- Whether directly or indirectly, Total RVU's are the principal factor in reimbursement.
- Frequently cited in MGMA, RVU's are used to measure practice costs and provider compensation.

Seven components of a fee

- **RVU's-Relative value units**
 1. Work
 2. Practice
 3. Malpractice
- **GPCI's-Geographic Practice Cost Indices**
 1. Work
 2. Practice
 3. Malpractice
- **Conversion factor**

Current reimbursement for a 99213

- Considered “the allowed amount” all providers in New Mexico currently receive \$67.32 (in total) from Medicare.
- *All RVU, GPCI, and Conversion Factor detail can be found at www.trailblazerhealth.com*

99213 for 2011 in New Mexico

		Final 2011
1	Work RVUS	0.9700
2	Work GPCI	1.0000
a	Adjusted Work RVU's	0.9700
3	Practice	0.9900
4	Practice GPCI	0.9470
b	Adjusted Practice RVU's	0.9375
5	Malpractice	0.0700
6	Malpractice GPCI	1.0540
c	Adjusted Malpractice RVU's	0.0738
a+b+c	Sum of adjusted RVU's	1.9813
7	Conversion Factor CF	\$ 33.97640
(a+b+c)*7	NM Medicare Reimbursement	\$ 67.32

New Mexico Medicare 99213...history

	2007	2008	2009	2010 First half of year	2010 Second half of year	Final 2011
Work RVUS	0.9230	0.9199	0.9200	0.9700	0.9700	0.9700
BNAV	0.8994	0.8806				
Work GPCI	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Adjusted Work RVU's	0.8301	0.8101	0.9200	0.9700	0.9700	0.9700
Practice	0.7100	0.7300	0.7500	0.7900	0.7900	0.9900
Practice GPCI	0.8880	0.8880	0.8900	0.9460	0.9460	0.9470
Adjusted Practice RVU's	0.6305	0.6482	0.6675	0.7473	0.7473	0.9375
Malpractice	0.0300	0.0300	0.0300	0.0500	0.0500	0.0700
Malpractice GPCI	0.8800	0.9890	1.0960	1.0960	1.0960	1.0540
Adjusted Malpractice RVU's	0.0264	0.0297	0.0329	0.0548	0.0548	0.0738
Sum of adjusted RVU's	1.4870	1.4880	1.6204	1.7721	1.7721	1.9813
Conversion Factor CF	\$ 37.8975	\$ 38.0870	\$ 36.0666	\$ 36.0791	\$ 36.8729	\$ 33.9764
NM Medicare Reimbursement	\$ 56.35	\$ 56.67	\$ 58.44	\$ 63.94	\$ 65.34	\$ 67.32

SGR-Sustainable Growth Rate

- Established in 1997 by Congress as a way to control Medicare Part B spending over time.
- Actual growth in physician spending was not to exceed targeted growth,
- Between 1998-2001 there were positive adjustments to physician reimbursement, however, from 2002 through 2009 the adjustments required cuts.
- Congress each year intervened, either freezing rates or offering nominal increases
- Currently, the SGR calculation will require a 30% cut in physician reimbursement beginning in January of 2012.

Know how you are reimbursed

- Contracts with carriers are usually negotiated based on a percentage of New Mexico Medicare
 - Sometimes there is only a single multiple
 - Sometimes the multiple is separately negotiated for E&M, Surgical, radiology, pathology
 - Sometimes you might have a contract with a carrier that uses an internally developed RBRVS model
 - Could also see a fee schedule that spans multiple years, i.e., surgical on a 2001 NM Fee Schedule and all other services on the current NM Fee Schedule
 - RBRVS could be held constant on a given year but the conversion factor is negotiated

Examine your EOBs closely!

- When reviewing EOB's
- First, get your contracts together, make sure you have your current amendments
 - Are individual line items, if denied, followed up on?
 - What is the process to follow up?
 - Is the practice ever getting paid 100% of the billed amount?

Recalculation of allowable per contract

This particular contract has negotiated certain carve outs,

This carrier has established its own RVU schedule

Surgical procedure with highest RVU's is paid at 100% of the allowable, all additional procedures are reimbursed at 50% of the allowed fee

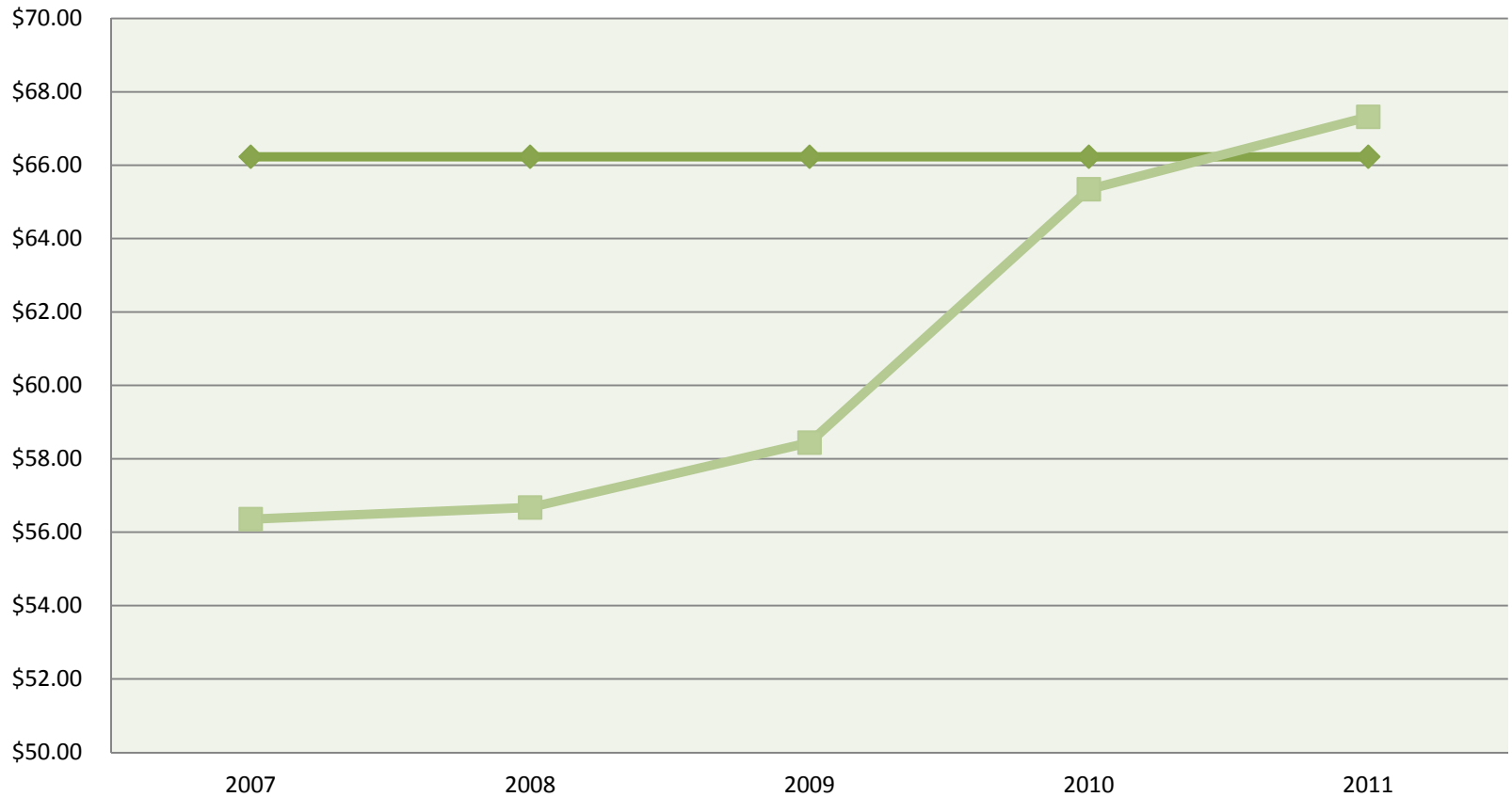
9/17/2010

	CPT4 Code	Gross Charge	Ins Co RVU	RVU Fee	Carve out	Multiple srge disc	Calculated Allowed	Allowed by Carrier	Variance to Allowed
Shoulder arthroscopy/surgery	29827	\$ 4,199.00	27.00890	\$ 1,705.34		100%	\$ 1,705.34	\$ 1,705.29	\$ (0.05)
Shoulder arthroscopy/surgery	29826	2,730.00	16.51474	1,042.74	\$ 1,255.94	50%	627.97	627.97	-
Remove/transplant tendon	23440	3,084.00	18.80110	1,187.10		50%	593.55	593.55	(0.00)
Shoulder arthroscopy/surgery	29823	3,030.00	15.45764	976.00	1,168.46	50%	584.23	584.23	-
Shoulder arthroscopy/surgery	29824	1,650.00	16.58468	1,047.16	1,103.82	50%	551.91	551.91	-
Acrimio/clavicular canvas	L3670	164.00		-			100.19	100.19	-
		<u>\$ 14,857.00</u>					<u>\$ 4,163.19</u>	<u>\$ 4,163.14</u>	<u>\$ (0.05)</u>

Contract Summary

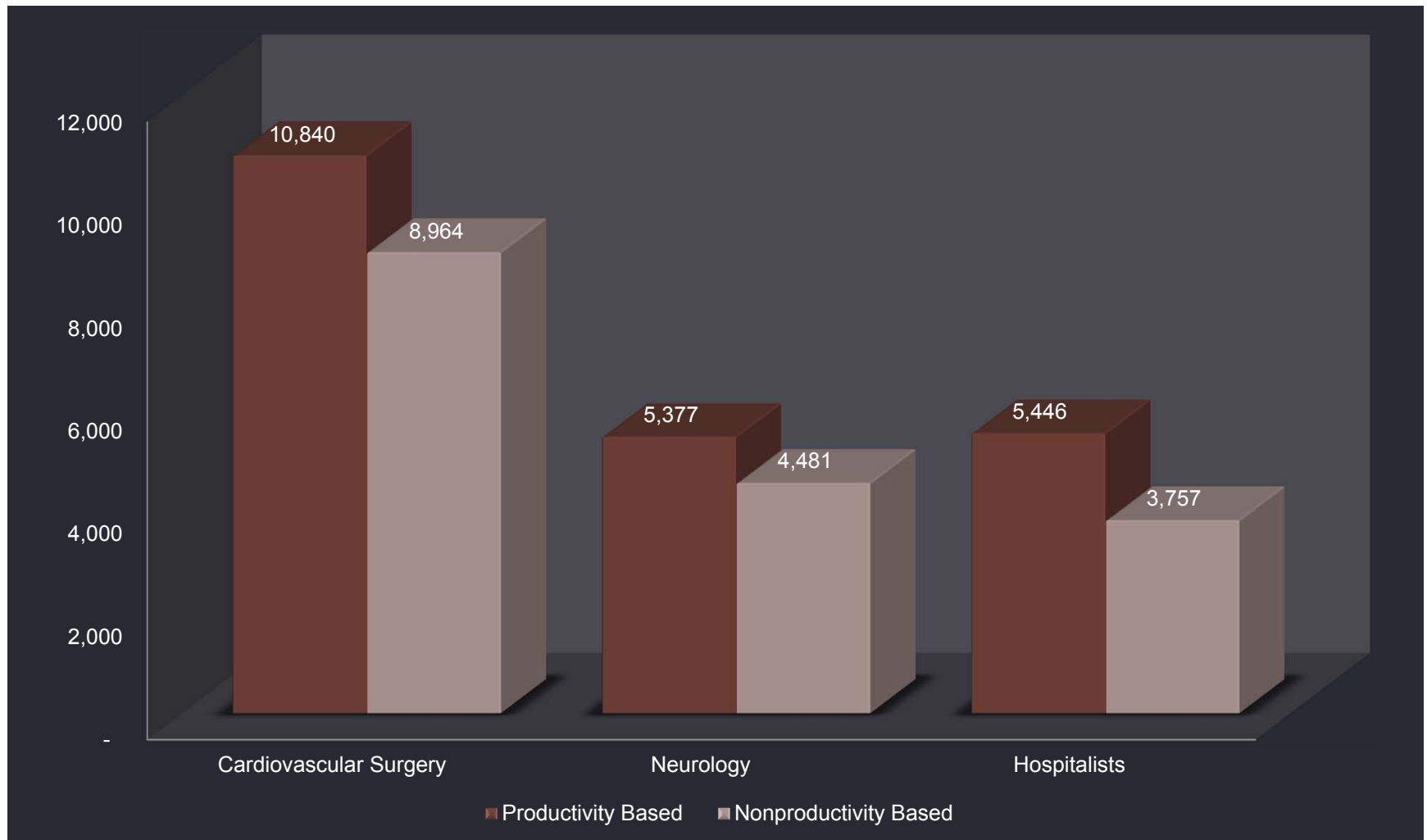
Commercial Comparison Top Codes Top Payers					
	Code	Current NM Medicare	Plan A	Plan B	Plan C
<u>E&M</u>	92222	\$ 70.40	99%	155%	125%
↓	92444	\$ 132.14	99%	155%	125%
	92012	\$ 73.96	99%	155%	125%
	92111	\$ 43.36	99%	155%	125%
	92333	\$ 74.79	99%	155%	125%
	92285	\$ 38.93	99%	155%	125%
	90203	\$ 97.91	99%	155%	125%
↓	90224	\$ 152.63	99%	155%	125%
<u>Surgical</u>	55051	\$ 47.55	120%	155%	142%
↓	50533	\$ 290.11	120%	155%	142%
	20555	\$ 978.73	120%	155%	142%
	50561	\$ 702.95	155%	155%	142%
↓	50557	\$ 130.66	120%	155%	142%

Pay attention to rates

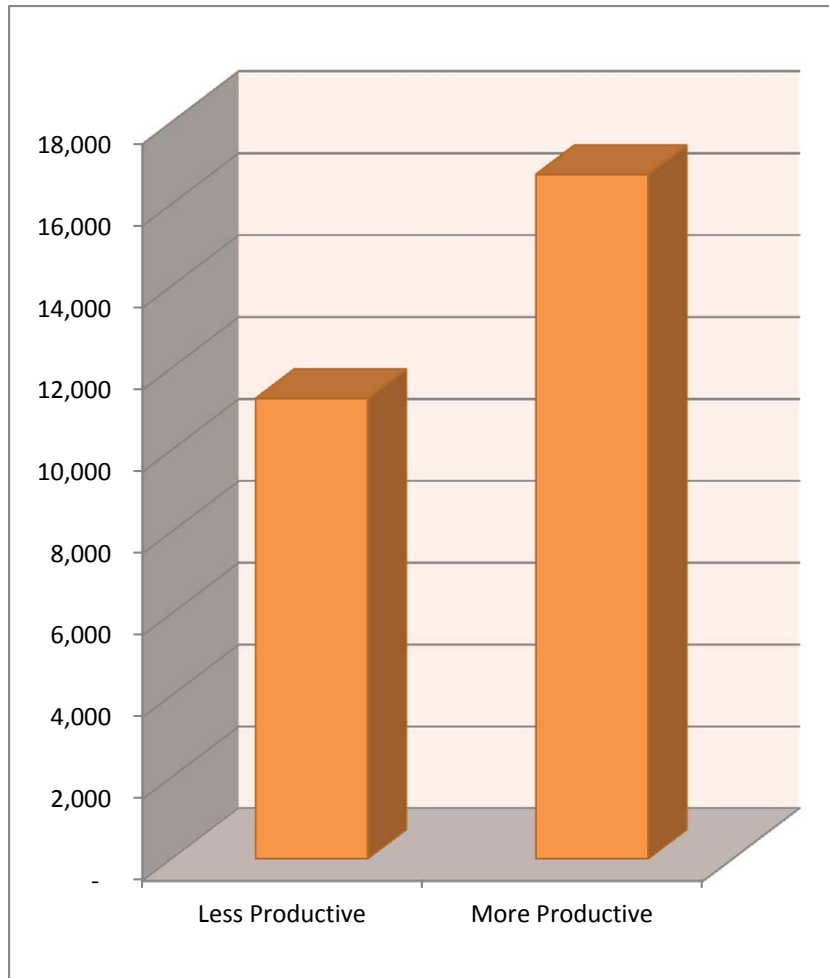


	2007	2008	2009	2010	2011
HP 99213	\$66.23	\$66.23	\$66.23	\$66.23	\$66.23
NM 99213	\$56.35	\$56.67	\$58.44	\$65.34	\$67.32

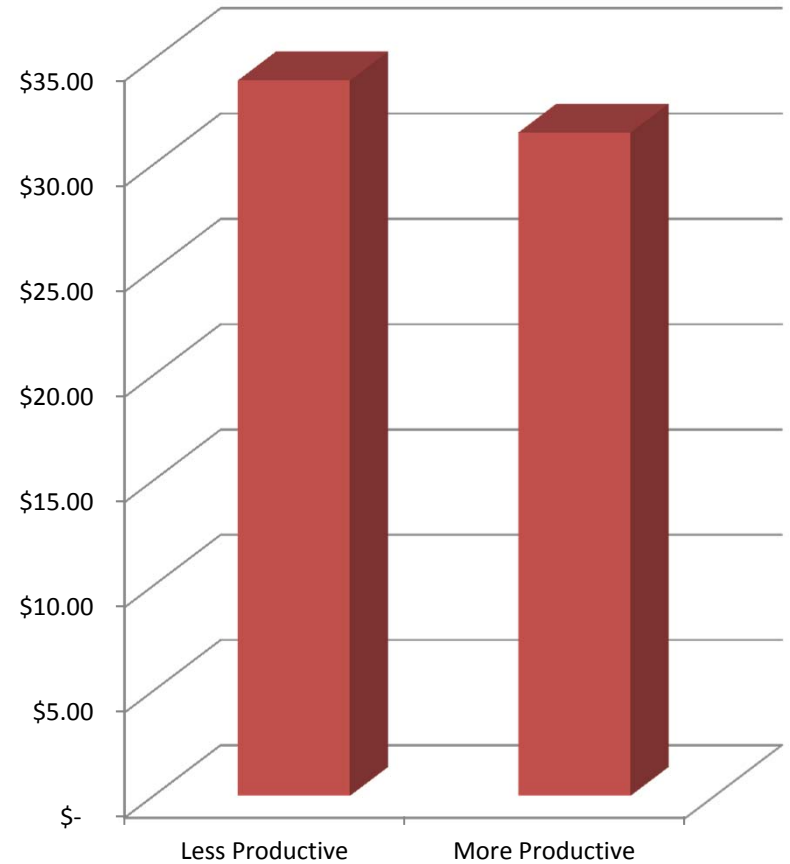
Work RVUs by method of compensation plan



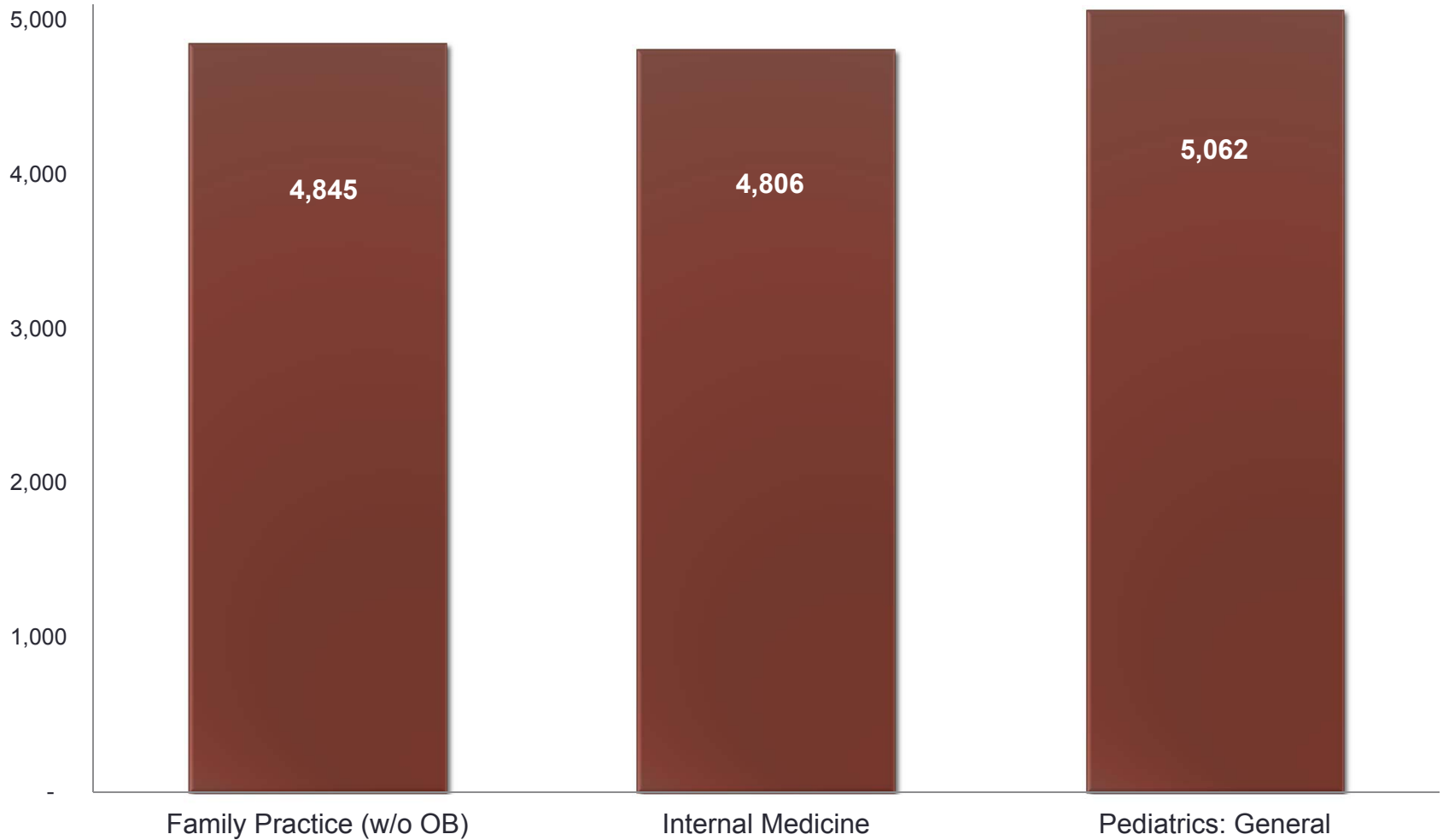
Median Total RVU's per physician FTE



Median Total Operating costs per total RVU



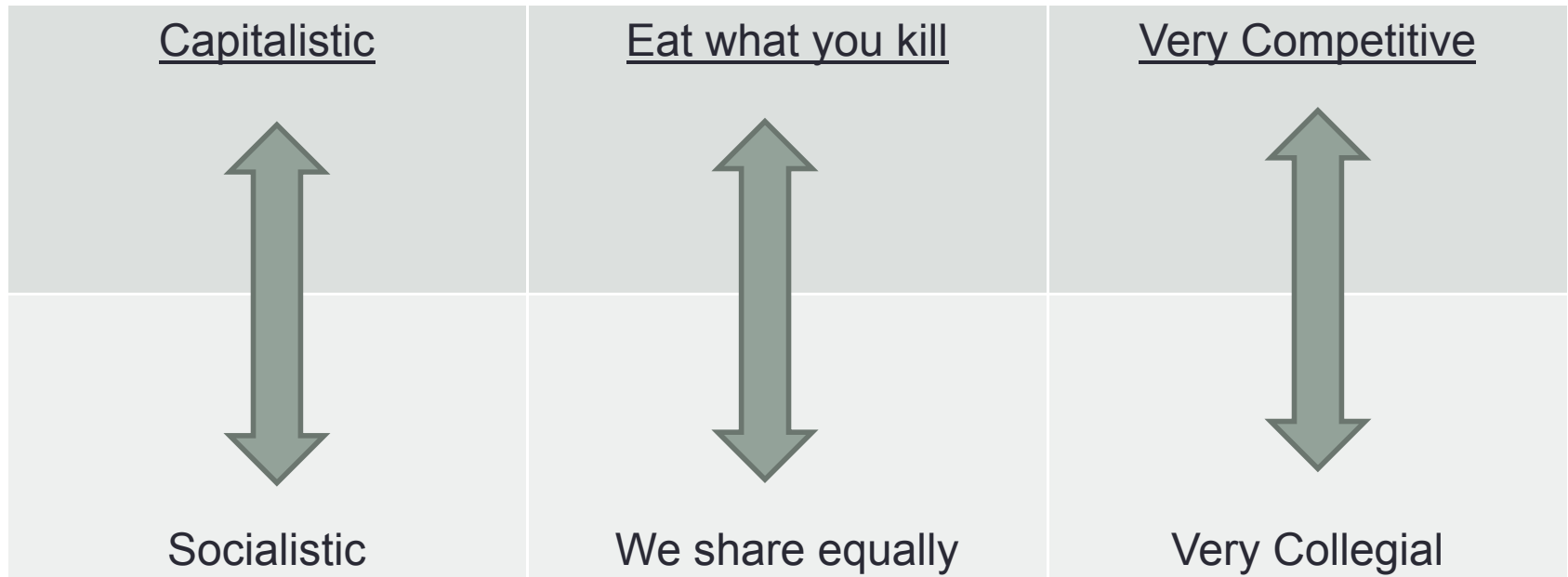
Annual primary care median physician work RVU's 2009



PHYSICIAN COMPENSATION

“You’ve seen one plan,
You’ve seen one plan.”

- Vary between practices, even with a multispecialty group, departments might have different philosophies
- Share some fundamental similarities



Equal sharing

This is the simplest arrangement administratively. It is based on an economic model that presumes all participants are equally skilled and motivated and are performing at the same level. This model discourages overutilization but offers no incentive for productivity, however measured. Additionally, it penalizes high producers and allows low producers to "coast."

Productivity

The obvious advantage of this model is that it encourages extra professional effort and seems "just" in a capitalistic economic system. The disadvantages are that it feeds intragroup competition, requires substantial accounting management to assign overhead burden fairly, encourages overutilization and can even discourage citizenship, such as practice governance and management, teaching and other activities not connected with patient visits.

Salary

- Straight salary is easy to administer but can disincentivize entrepreneurship and may indebt the corporation if actual revenue is less than what is being paid out.

Salary plus bonus

- A significant advantage to this method is that it offers security. It also enables physicians to increase their income through performance. On the down side, this method may cause minimum work standards to become de facto norms. This method also places a large component of income at risk, depends on subjective measurements in apportioning that at-risk portion, and can be complex to design and administer.

Overhead

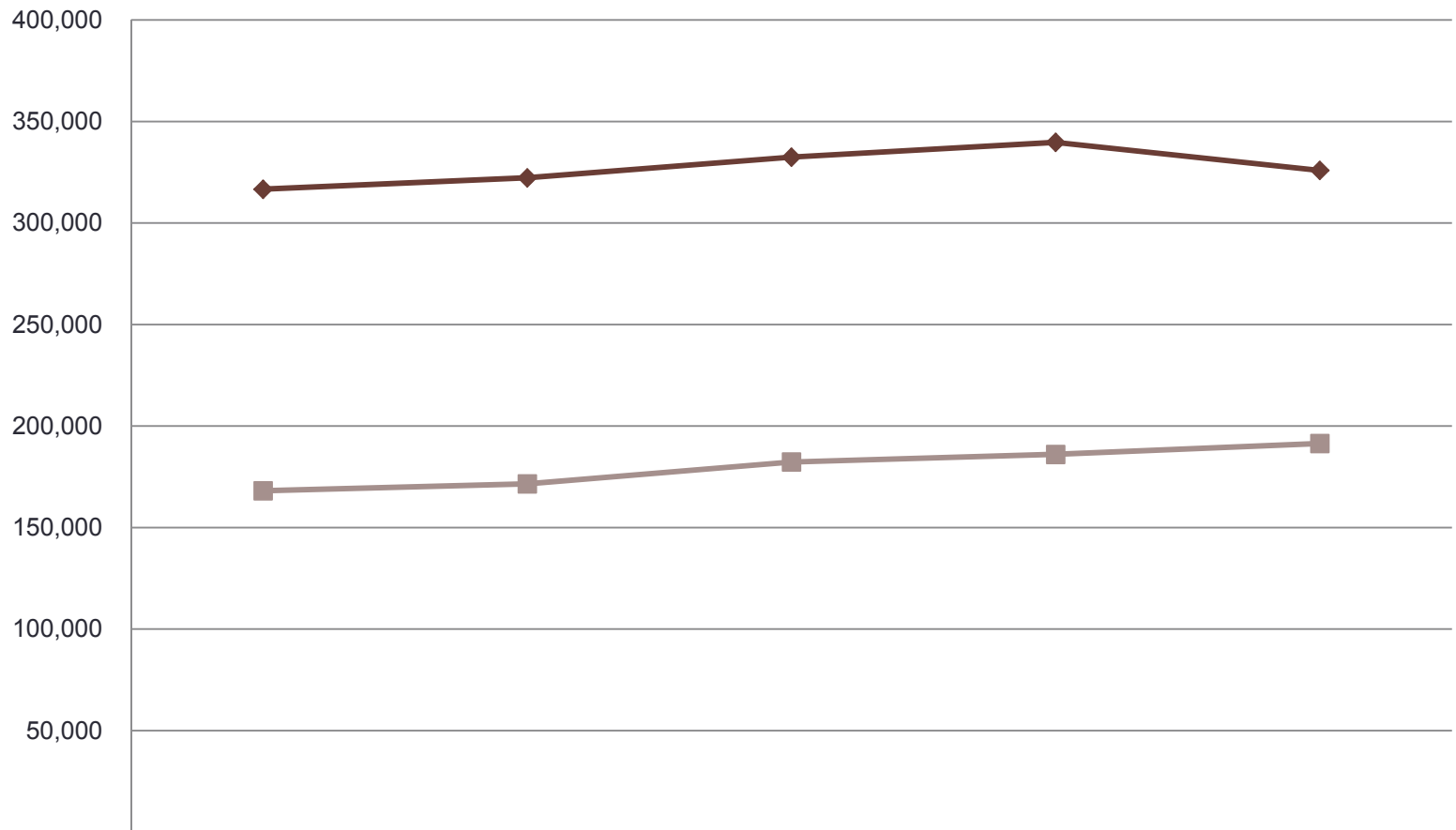
- How best to allocate overhead, if it is a factor in the compensation model?
 - Based on a percentage of collections
 - Shared equally
 - Combination of both methods, 40% shared equally, 60% based on resources consumed
- Ancillary revenue,
 - Practice receives a global payment, technical component is first used to cover technical expenses, profit then shared.
- Billable supplies
 - The expense should be allocated to the provider

How best to allocate expenses of the practice?

- Flat charge
 - Utilities
 - Certain administrative costs
- Based on production
 - Billing office staff
 - Registration staff
- Actual usage
 - Billable supplies
 - CME
 - Vehicle
 - Malpractice



Annual median physician compensation trend 2009



◆ Specialty Care	316,620	322,260	332,450	339,740	325,900
■ Primary Care	168,100	171,520	182,300	186,040	191,400

ACO's on the horizon

- ACO's will require physicians and hospitals to work more collaboratively , either structurally through ownership/employment or contractually.
- ACO's must have sufficient primary care providers in order to be approved by CMS
- First Medicare ACO's will be established January 2012,
- Many insurance companies are looking to joint venture with providers to build ACO's as well.
- If you don't work with physicians today, soon you will.

To reach me

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