REVIEWING ALTERNATIVE WAYS OF PRACTICING MEDICINE TO OVERCOME REDUCED PHYSICIAN REIMBURSEMENT FEE SCHEDULES WITHIN AMERICAN HEALTH NETWORK

By

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Introduction

In recent years there have been many changes with the economy as well as other aspects affecting the healthcare industry. As a member of the management team of American Health Network’s Noblesville office, it falls on the author’s shoulders to find ways to reduce overhead because of the reduced insurance reimbursements. These reimbursements have been shrinking year after year and while some insurance companies like Anthem and Medicare are finding ways to incentivize the physicians, it means more man hours spent by their staff jumping through the hoops required by the insurance companies.

Another area of great concern for the management team is the large number of high deductible insurance policies that employers are offering to their employees because of the high cost of insurance premiums. For the physician this means that there are high balances for the patients to pay out of pocket which leads to two things. The first being that the patients wait longer between office visits or wait until the sniffle has turned into something more serious before making an appointment and the other thing this leads to is a high increase in non-payment by the patients ultimately leading to a higher demand for the collections department and bad debt counseling. For the physician this not only means being paid much less for the services already provided as well as not being able to provide the quality of care to those who delay making an appointment to be seen because they cannot afford to be seen.

For this case study, the author looked at the insurance reimbursement trends with American Health Network as a whole not just the Noblesville office. The author interviewed several physicians on the Management Council of the company as well as researched several medical journals to see the industry wide trends. The author also researched alternatives to
overcome the decrease in insurance reimbursement to explore other ways to practice medicine more efficiently and effectively.

Purpose of the Study

The topic of insurance reimbursements was chosen because it presents a real challenge and concern for the management team of American Health Network. This study will cover the current insurance reimbursement fee schedules and will look at alternative ways to increase physician revenues. The author will also be looking at the previous years to indicate what the insurance reimbursements will do in the years to come in contrast to the skyrocketing malpractice insurance premiums and other expenses.

The physicians and management teams are concerned about what the future of practicing medicine will look like? Will it is possible for the physicians to continue practicing medicine in the way they have always practiced or will they have to re-evaluate what they are doing? This causes a great concern for the management team because they have responsibility of the security and wellbeing of the employees of American Health Network resting on their shoulders.

This case will look at the insurance reimbursement trends of recent years and the expected trends in the upcoming years. The author will also be looking at alternative ways to practice medicine in order to increase the practice revenue to ensure job security for the employees.

Limitations of the Study

Because many health care facilities are privately owned, the author will not be able to view insurance reimbursements of these facilities and will only be looking at American Health Network. The author will also not be including hospitals or physician groups backed by hospitals in this study as these groups fall into different reimbursement categories. The author will also not
be looking at the contracting aspect of building relationships with insurance companies because many of these relationships are much older than the author.

Significance of the Study

This study will help to provide some insight regarding the future of medical practices as they are today. By looking at physician reimbursement trends, it will show what can be expected with reimbursements in the future. This study will help the physicians determine what the future will hold in regard to how they will continue practicing medicine. It will help the management team evaluate the best ways to manage office overhead in order to maximize the profitability of the practice which all depends on the expected future insurance reimbursements.

This scenario presents a real problem to the physicians and staff of American Health Network. The future of the business, the employees, the physicians, as well as the care of the patients all hinge on the success of the practice. What good is all the education that the physician acquires from years of practicing if he or she cannot afford to keep the doors open?

Significance to the Writer

Much responsibility falls on the shoulders of the management team, including the author, which makes the topic of increasing revenue to the practice and physicians of great importance. The future of all involved depends on the management team finding a solution to this very real problem. If the way the practice operates in the future does not change, the practice may not be around in the future. The recent economic downturn has made it a great concern for the author and the remainder of the management team. They must ensure that the practice can sustain in order to provide care to the patients and employment for the employees.
Significance to the Department, Division, Company, Alliances, etc

American Health Network is a company that is owned by its physicians. As a company, insurance reimbursements provide the means to keep the doors open. The company was started by physicians who wanted more negotiating power with the insurance companies and this is better achieved in larger numbers.

In recent years American Health Network has used alliances with other physician groups and hospitals to increase insurance reimbursements. In the health care industry these arrangements are called Billing Under Arrangement. While profitable for a short time, many insurance companies begin to understand these arrangements and how they work and alter future contract negotiations with the parties involved to eliminate these arrangements. During the contract negotiations with the insurance companies, insurance companies will threaten to reduce reimbursements unless these arrangements are terminated.

Breaking the company down into individual departments such as Payroll, IT, Human Resources, Billing, Collections, Payment Posting, Contracting, and Finance, insurance reimbursements are required in order to do business. Again without the reimbursements, there will be no new computers or programs, no money for payroll, no money for benefits, and the list goes on and on. All business activities are tied directly to the insurance reimbursements.

Looking deeper into the departments, many employees really do not understand how insurance reimbursements work. In many cases, these employees have not been with the company long enough to understand the big picture of what each department does and how each task or duty affects the tasks and duties of other departments. For example, if someone in checkout uses an incorrect diagnosis code when billing out an insurance claim, that claim will come back as denied and the billing department will then have to amend the claim and rebill it.
This affects the amount of reimbursement the physician will receive as well as the length of time it will take for the physician to receive that reimbursement.

Within American Health Network are independent physician offices. Each office is made up of between two physicians and twenty physicians. Each office has a name and works like a company within the company. Although all the physicians are operating under the same contracts with the insurance companies and bill under the same Tax ID number, some offices are more profitable than others. Much of this boils down to the business minds of the physicians as well as their management teams. When one office is more successful in certain areas, they are used as an example to the other offices trying to increase profitability, efficiency, and effectiveness.

In regard to insurance reimbursements, when one office finds a way to increase reimbursement in certain areas, this is shared with the other offices to duplicate the process in an effort to make all offices as profitable and efficient as possible. In a sense, there are multiple management teams working together with different levels of experience and success maximizing the insurance reimbursements.

Broader Implications

As a whole, the medical industry in the United States is in the same situation. Hospitals do fall into a different category with insurance reimbursements, but they too are seeing the decreasing trend of the insurance reimbursements (Koepke, 2009). Many physicians and physician groups are already attempting alternative ways of practicing medicine to counteract the decreasing reimbursements, such as limiting the number of new patients accepted with Medicare or Medicaid insurance (Siegel, 2009). Concierge medicine is quickly gaining more popularity and could be the next best thing for physicians.

At this time, this topic does not have global significance. Some countries have universal
health care systems where insurance reimbursements are not an issue for the physicians, while others countries have less developed methods of physician reimbursement.

Organization Overview

In 1977, Noblesville Family Care started initially with two physicians and then two years later a third physician joined. Over the next seventeen years several more physicians joined the practice and because of a conflict of interest, one physician left with the encouragement of the other partners. The physicians owned the practice as equal partners and were compensated in an expense minus revenue formula. As the physicians wanted to grow the practice and see more patients in a day, they added several physician assistants to the practice. At this time, the practice was a stand-alone practice meaning they were not a part of a larger physician group. They treated their staff like family and had the feel of a small practice, not that of corporate medicine. The physicians knew all the staff members as well as their spouses and kids (W. Beaver, personal communication, Dec. 11, 2009).

Noblesville Family Practice was successful but the physicians thought they could be more successful if they joined a larger physician group. There were a number of benefits to joining a larger group such as better employee benefits, better contract negotiating power with insurance companies, better marketing power, better human resources development and management, and better IT support.

In 1995, American Health Network was created by a liaison between Anthem and the physicians. In 1998, Anthem broke off and American Health Network was created. It was founded as a way to provide better patient care to the patients. The goals of the company are to provide the most complete and highest quality medical care available to make their delivery system more attractive to insurance carriers, to build an organization that has the incentives
properly aligned by using a physician compensation model that encourages high quality patient care and expense control, and continue developing and deploying their disease management programs that are recognized nationally as being superior to all others in terms of patient outcomes and controlling health care costs (American Health Network History, 2009).

Noblesville Family Practice joined American Health Network in 1995. Several of the physicians of the Noblesville office are on the various management boards with the company and the office in general plays a huge part in moving American Health Network towards greater success. (Beaver) Over the years, American Health Network has grown and spread though out Indiana and Ohio and now has more than two hundred physicians on board and employs more than sixteen hundred employees (American Health Network History, 2009).

Identification and Discussion of Issues

In order to analyze the details of the case, the author must first look at several key areas of discussion. Reduced insurance reimbursements mean several different things to different areas of the practice. To the physicians it means they have to see more patients in a day in order to show the same amount of revenue. To the management team this means the staff has to help cut overhead while working more efficiently and effectively. It also means they may have to work with fewer employees to get the job done. To the billing office it means there will be more insurance denials that will have to be re-filed to the insurance companies’ specifications, as those can change at any time.

Medicare Influences on other Insurance Companies

It is always the trend that Medicare sets the guidelines for the majority of other insurance companies to follow (Howard, 2009). The troubling part is that these guidelines are so stringent, many claims get denied for not being medically necessary and ultimately this affects the patient’s
care. When looking at the Medicare system as a whole, how can one company have such a weight on the remaining insurance companies? It is understood why Medicare sets their own guidelines but unfortunately other companies feel that if Medicare can get by with it, why not the others (Howard, 2009).

For the Noblesville office in 2008, Medicare represented 21.3 percent of total reimbursements which is the second largest of all insurance payers. In dollars, this represents $5.5 million in reimbursements. With these figures, Medicare plays a large part of the total revenue of the practice (American Health Network Financials, 2009).

Anthem or Blue Cross Blue Shield is the number one payer for the Noblesville office and represents 42.7 percent of total reimbursements or $9.9 million. Anthem is an insurance company that closely follows the guidelines set by Medicare. At one point in American Health Network’s history, American Health Network and Anthem were partners working together to better the healthcare industry. That alliance was severed many years ago and the two have since become enemies on opposite sides of the reimbursement issues. Anthem is considered the big insurance giant and can do whatever it is they please because of the size of their profit margins each year (American Health Network Financials, 2009).

Another concerning issue for the health care industry is the influence and control the government has on Medicare. How can a group of politicians determine what is deemed medically necessary? Unfortunately, government regulations heavily control what happens within Medicare, thus influencing other insurance companies like Anthem as well. At what point did the physicians lose their ability to use their expert knowledge to determine what each patient needs? This is a bit concerning to many in the health care industry including the physicians of American Health Network.
Questions to Be Answered

What are the alternatives available for the physicians?

The author will explore ways to overcome the reduced insurance reimbursements to allow the physicians to be more profitable and to keep up with the cost of doing business. Most physicians chose to go into the medical field because they wanted to care for and cure their patients, not just run a numbers game. The previous ways of practicing medicine may not be the way of the future for many physicians because it is forcing them to see more patients in a day just to try to stay afloat with their operating overhead costs. The current craze in the medical field is concierge medicine and the author will explore the positives and negatives of this type of practice and whether the Hamilton County area can support this type of practice. The author, as a member of the management team of the Noblesville office, will explore ways to increase revenue while protecting the well being and security of the employees and the physicians as well as the patients. The goal of the author is to find a way to ensure the practice is around for many years to come for all who have a vested interest in the practice.

What are the long term effects of reduced insurance reimbursements in the family practice segment of the health care industry?

As Medicare and other insurance companies reduce their reimbursements, where does that leave the physicians? The patients are trying to demand more and more of the physician’s time day in and day out while the physician is attempting to see more patients in a day. This roller coaster ride continues day after day in the practice. Each day the physician is forced to see more and more patients to maintain the level of revenue that is needed to cover the cost of doing business. At what point will the physicians no longer be able to do this? When will it all stop? Will we begin seeing practices that are open through two and three shifts a day to keep up with
the demands? When and if this becomes the case, will medicine become even more impersonal moving to a factory like setting? Is this really what the patients want?

**What does a reduced insurance reimbursement mean for the patients?**

Many patients really don’t understand how the entire insurance system works. As long as their claims get paid, they don’t worry. They believe the physician is making a lot of money and lives in a big house. But is that really the case? In the large scheme of things, a change in the health care industry to a concierge medicine practice could leave many patients without a family physician if they cannot afford to pay the annual costs the physician can charge just to be their physician. Where will that leave these patients and what will they do for care? But also what will happen to the patients with lower paying insurance reimbursements when their family physician can no longer afford to care for them? There are already not enough family physicians to care for the American population. The Association of American Medical Colleges projects that by 2025, there will be a shortage of 124,000 physicians because of the cap on medical school enrollment from the 1980’s. The population growth has outpaced the number of new newly trained physicians (Ruiz, 2009).

**Methodology**

In order to answer the questions listed, the author researched several different medical journals and looked at the financial data from the previous years of American Health Network as well as the Noblesville office. The author also did several personal interviews of physicians from the Noblesville office as well as their executive director. The author also researched the topic of concierge medicine and how it would affect the practice as well as the physicians and the patients.
Information and Literature Review

Medicare

Medicare is looked as a source for innovation because it is the largest single payer for health services in the United States, accounting for more than 17 percent of national health care expenditures in 2005. Medicare’s elderly and disabled patients depend on Medicare for quality, effectiveness, and coordination of the healthcare they receive. Medicare has tremendous pressure on its solvency due to its size, spending more than $425 billion in 2007, and its projected rapid growth, which will be near $842 billion by 2017. This tremendous pressure has been placed on the federal budget and the economy as a whole. In order for Medicare to be able to meet the needs of its patients, to remain solvent, and to serve as an example for improvements throughout the health care sector, it must be the leader in improving both the clinical care that it buys and its cost-effectiveness (Davis & Guterman, 2007).

In 2004, it became very clear to the Medicare Trustees that there would be challenges to the Medicare system. Part A Hospital Trust Fund, which is the hospital portion of Medicare, will be exhausted by 2019, which is seven years earlier than indicated by the prior year’s Trustee report. The outpatient drug benefit plan as well as the Improvement and Moderation Act have greatly added cost to Medicare. With these additions, Medicare spending is expected to increase at a faster pace than either worker’s earnings or the economy overall (Harrington, 2004).

In 2005, Congress intervened and Medicare increased total reimbursements to physicians by four percent. In the Balanced Budget Act of 1997, Medicare was due to implement reimbursement cuts in 2005. This intervention in dollars meant more than $2.2 billion to split up; hospitals got a little more than six percent for outpatient care which equals $1.5 billion and
the rest went to physician groups. The increase for physician services worked out to 1.5 percent equally across the board (Weber, 2005).

In 2005, there were also additional sources of revenue offered by Medicare for physicians. Medicare had a new focus on preventive care and covered additional blood glucose and cholesterol tests for those at risk for diabetes or heart disease. Despite the increased Medicare payment schedules, physician reimbursements continued to trail inflation by a large amount. The annual Medicare payment updates to physicians only increased a small 1.7 percent on average (Weber, 2005).

The effect of the increased payments by Medicare in 2005 triggered more physician office visits which led to a wide range of other medically necessary tests such as laboratory testing to monitor or treat conditions that might have otherwise gone undetected and untreated. The downside to the surge of claims was the fear that it would lead to future Medicare reimbursement cuts which were already slated to take place in 2006 and beyond (Weber, 2005).

There was the start of a series of reductions in 2007 that were listed in Medicare’s The Balanced Budget Act of 1996. This act spelled out the amount the U.S. government would reimburse health care providers through the Medicare system. Legislators did eliminate the decreases that were to take effect in 2007 but they left in place those scheduled for future years. It is estimated that these physician reimbursement cuts would be between four and five percent annually for at least the next several years. The American Medical Association conducted a survey in 2006 and reported that 82 percent of physicians would be faced with projected cuts of 34 percent in reimbursements by 2015. These changes will make significant changes in their practices and possibly the access to care for their patients (Hodges & Henson, 2009).
It causes great concern to researchers as they consider how physicians will cope with these reduced reimbursements. There are several different ways the physicians can choose to handle these reimbursement cuts. First, the physicians may choose to shift the burden of declining government reimbursements onto private payers. As second way the physicians may respond might be to reduce the quality and quantities of services provided. On the opposite spectrum, physicians might try to offset the declining reimbursements by ordering additional tests or procedures to boost revenue. And yet another concern is that the physicians may select patients with the highest payment rates when deciding which patients to treat (Hodges & Henson, 2009).

In fiscal year 2009, there was yet another long list of changes to the Medicare system. The Centers for Medicare and Medicaid Services (CMS) made more changes in the way Medicare reimbursed for hospital-acquired illnesses. These illnesses were considered secondary conditions because they were not present when the patients were admitted to the hospital and CMS felt that they could have been prevented easily if the hospital had standards of practice in place. “The goal of CMS was not only to make adjustments in Medicare payments for quality of care errors that are preventable in their eyes but also is also looking to improve Medicare’s strategy to move the health care industry to adopt evidence-based, research-driven health care practices and to more fully embrace patient safety initiatives” (Silveria, 2009, p. 34). Medicare did not want to penalize the health care environment but to improve patient care and safety (Silveria, 2009).

CMS continues to slowly transition to base more hospital reimbursements on the quality of care received. Eleven conditions such as pressure ulcers or cerebral infarction (stroke) have been identified that if they are not reported at admission but reported during the hospital stay will
likely cause the hospital to see reduced reimbursements. Another concern for CMS is the number of hospital readmissions. More than 18 percent of Medicare patients are readmitted to the hospital within 30 days of discharge. Eventually, CMS may reduce the reimbursement for avoidable readmissions (Thompson & Wolters, 2008).

Accurate billing greatly impacts the Medicare reimbursements the hospitals receive. As other payers are adopting Medicare’s policies, hospitals will see an even greater impact on reimbursements if they are not capturing all data necessary to be properly reimbursed for services rendered, according to David Thompson (Thompson & Wolters, 2008).

Charland (2007) stated “high quality and efficient health care is the top priority for CMS and it recognizes that the current Medicare payment system offers providers little incentive to support this priority” (p. 60). CMS proposed to change this in 2005 so that Medicare can reward providers for meeting measures of healthcare quality (Charland, 2007). Initially CMS developed a voluntary quality reporting program (PVRP) in 2005 to encourage physicians to report information on the quality of the care they were delivering. Physician Quality Reporting Initiative, PQRI, was then built on the original concept of PVRP with payments linked to reporting quality information. Data submitted from 2007 showed that about sixteen percent of eligible professional participants submitted information on at least one quality measure in the program. About half of those who participated were successful in meeting the requirements of the program and reporting and received an incentive payment. As the program continued to grow, additional reporting options for measures were implemented, and participation and incentive payments have grown (Physician Quality Reporting Initiative 2007 Reporting Experience, 2007).
"With practice management expenses continuing to escalate in the forms of salaries, information technology, rent, insurance and other costs, reduced Medicare reimbursements could have a significant impact on physician income" (Sears, 2008, p. 50). Physicians are looking for additional ways to supplement their revenues to sustain current levels of income. Many are looking at the PQRI measures that Medicare is incentivizing them on but physicians cannot expect the bonus payment for participating to help their financial situation too much. The reporting bonus is very small in contrast to the difficult and time consuming reporting methods and will not come close to making up for the potential loss in the professional services component (Sears, 2008).

In 2007, Congress proposed what has been called value-based purchasing or VBP. The goal is "to transform Medicare from a passive payer of claims to an active purchaser of care", (Andrews, 2009, p. 4). VBP proposes to link payments to results, including quality, patient satisfaction, efficiency, and other measures. CMS suggests that hospitals should be rewarded for improvements from a baseline. For VBP, hospitals will be ranked against national benchmarks and must sustain or improve those ranks from one year to the next (Andrews, 2009).

VBP will also likely bring changes not only to hospital reimbursements under Medicare but also will influence commercial payment methods as well. History shows that whatever new incentives Medicare incorporates, they will also be incorporated by commercial payers across all their products (Andrews & Wessels, 2009).

VBP represents an important opportunity for all healthcare providers. It allows them the opportunity to show they are providing the best possible care for their patients but also offers an incentive to step up their efforts toward achieving continuous improvements. Unfortunately, majority of hospitals will lose some Medicare reimbursements under VBP. Beginning fiscal year
In 2013, VBP will phase in payment adjustments by withholding two percent of Medicare reimbursements. The percentage of withholding will increase by one percent each year for five years to fiscal year 2016. These monies will go into the risk pool to be dispersed to the hospitals above the 26th percentile (Andrews & Wessels, 2009).

The goal of VBP is to have hospitals in the 75th percentile in the performance measurement system that includes both quality and patient satisfaction measures. Those hospitals in this percentile will receive a small bonus, approximately three percent of the dollars at risk. The bonus funds will come from monies withheld from and not returned to hospitals in the lower percentile hospitals. Hospitals below the 26th percentile will not see any risk-pool dollars returned. Hospitals between the 26th and 75th percentile will receive risk pool dollars on a prorated basis (Andrews & Wessels, 2009).

The history of Medicare hospital inpatient margin percentages have eroded from a healthy 11 percent in fiscal year 2001 to an unhealthy and worrisome 3.6 percent in fiscal year 2008. “For fiscal years 2005 through 2008, the average annual increase in Medicare payments to hospitals under the inpatient prospective payment system declined to the point that the payments no longer cover the cost of providing care to Medicare patients” (Schuhmann, 2009, p. 54). During this same time period, the total patient numbers remained stable. This indicates that other payers in addition to Medicare are subsidizing the unreimbursed costs of caring for Medicare patients (Schuhmann, 2009). It is well known that the more severely ill patients require more care which incurs more costs greater than the reimbursement, whereas less severely ill patients will be profitable (Lindrooth, Bazzoli, & Clement, 2007).

Even though hospitals were able to shift some of the Medicare costs to other payers during the periods studied, overall patient service percentages remained negative throughout the
entire period. This means that the hospitals continued to lose money when providing patient care. If this trend continues, hospitals will have to depend on other ways to supplement their operations. Many hospitals depend on donations and incomes from investments to help subsidize losses from patient care. Unfortunately, the current economic conditions have hampered the public’s ability to continue making the same level of donations to the hospitals as in the past. There has also been a decline in the stock and bond markets, which puts additional stresses on the hospitals’ income from sources such as investments. Both of these trends severely affect the hospitals’ ability to rely on alternative sources of revenue (Schuhmann, 2009).

*Underinsured and Uninsured Americans*

The struggling economy has increased the number of unemployed and working poor who do not have health insurance (Schuhmann, 2009). It is no surprise that health insurance premiums have been rising each year (Sinnett, 2004). For past many consecutive years, insurance premiums have outpaced the consumer cost of living by more than two to one (Scott, 2006). Employers have been shifting costs to the employees for more than two decades attempting to manage their costs (Sinnett, 2004). Since there is no more shifting to do, employers have to absorb the higher health care costs, cutting into profits and during these tough economic times, potentially eating away at employee wages (Bachman, 2004).

Rising health care costs are only part of the reason for the increase in the Americans’ dissatisfaction in the healthcare system in recent years. Health care costs have continued to increase at rates that have surpassed inflation and employers have shifted additional costs to the employees in the form of higher out of pocket premiums, deductibles, and copayments. Slower economic growth during 2001-2004 added additional financial strain to families resulting in the
increases in poverty rates and the number of uninsured people (Banthin, Cunningham, & Bernard, 2008).

Altman (2007) stated “the United States has experienced a fifty percent increase in the number of uninsured since the 1980s, an increase in the percentage of out-of-pocket healthcare costs paid by consumers, and a decrease in the percentage of medical bills paid by patients at the time of service” (p. 25). Medicare, Medicaid, and private insurance are not paying what they used to (Altman, 2007).

Even with the Medicaid program, according to Cebula and Bopp (2008), over fifteen percent of the U.S. population is without health insurance. The noticeable decline in health insurance coverage has increased the awareness of the issue of health insurance coverage. The uninsured and underinsured suffer greatly as a result of reduced access to health services (O’Kane & Corrigan, 2008). In this sluggish economy, workers who have lost their jobs and health insurance for themselves and their families put off seeing the doctor unless it’s unavoidable (Weber, 2005). As costs spiral higher, more employers scale back on their coverage or drop it altogether catching working Americans in a vicious cycle of increasing lack of insurance, underinsurance, and inadequate care (O’Kane & Corrigan, 2008).

With the uninsured and underinsured population continuing to grow, and government reimbursements continuing to decline, improving payer mix has become a very real issue facing healthcare providers (Gentzel, 2005). Insurance plans negotiate seeking the best deal for their members. Medicare and Medicaid by law get the best deal with reimbursement for care, often being below costs (Bailey, 2006). Many HMOs, Health Management Organizations, are withdrawing from Medicare because as the physician costs increase at ten percent each year, the reimbursements only increase at a minimal rate per year (Russell, 2004).
Concierge Medicine

Concierge medicine or boutique practices began in 1996 and have moved from Seattle to South Florida and are now in more than fifteen states with some 300 physicians in the United States (Dakss, 2006). It started because many physicians were not having enough time to pay careful attention to their patients. Physicians have been adding to their patient loads in order to keep up with the rising costs of practicing medicine and reduced reimbursements. With concierge medicine, patients pay annual retainer fees outside of insurance to gain greater access to their physicians (Turner, 2009). This annual fee grants the patients access to the physician around the clock, same day appointments, more time face to face with the physician, personal coordination of care with specialists, personal follow up with admitted to the hospital, and even the physician’s cell phone number. A typical physician has a patient load of more than 2,500 patients; a concierge physician generally limits their practice to between 300-600 patients or more. This reduction of patient load allows the physicians to spend much more time with their patients (Taytro, 2009). In the current method of practicing medicine, physicians generally see between 25-35 patients a day and see patients in 5-15 minute increments. Many physicians are unhappy with the quality of care they are able to provide in this short amount of time with their large patient loads (Levine, 2008).

There is much controversy over the issue of concierge medicine. Many feel the approach violates medical ethics in abandoning poor patients (Levine, 2008). Critics say concierge medicine has widened the class disparities in American medicine. They also say it is escalated the shortage of primary care physicians by leaving more patients to be treated by a shrinking pool of physicians. However, advocates of concierge medicine reflect the deep concern with the two hour waits and ten minute appointments of the conventional care. Physicians are
experiencing great burnout and must see some changes before they might otherwise decide to hang up their stethoscopes for good (Sack, 2009). The thing with change is that you are either for it or against it and the physicians have to decide their future (Spector, 2010).

During this recession, physicians currently practicing concierge medicine were uncertain of what to expect of their patient numbers. Patients seem to have reaffirmed the importance of health care. Patients are forgoing other luxuries in order to keep their physician. For every one patient that chooses to leave a concierge practice, there is a waiting list of a 100 more ready to join (Sack, 2009).

Analysis of Issues

*What are the long term effects of reduced insurance reimbursements in the family practice segment of the health care industry?*

As Medicare and other insurance companies continue to cut their reimbursements to the physicians, it leaves much uncertainty of the future of the availability of primary care. The physicians are currently on a roller coaster ride; they have to see more patients each day in order to keep up with the increasing overhead of doing business and yet they are getting paid less and less for seeing their patients. It is as if they are just treading water trying to stay afloat.

The result is that doctors will consolidate into larger practices to spread overhead costs and cram even more patients into their already full schedules to make up in volume what’s lost in margin. Visits will be shortened and new appointments will be harder to secure. More physicians will close their practices to new patients, especially those carrying lower paying insurance such as Medicare and Medicaid (Gottlieb, 2006).

The patients are just as unhappy with the current system as the physicians. Patients do not like feeling like a number; they want to have a relationship with their physician. Waiting two
hours for a ten minute appointment does not constitute a relationship. Waiting two to three weeks to make appointment does not help the patients feel like their health is a priority. They want access to their physician when they have a question, not voicemail. And they want to get a call back from the physician when they are forced to leave a message. They want their referrals to specialists done in a timely manner as well as a feedback consultation from their physician.

What are the alternatives available for the physicians?

Based on the trends of Medicare reimbursement history as well as that of other commercial insurance payers, the physicians are left with only a few options. The first option for the physicians is to continue practicing medicine as they are today, seeing more and more patients each day to make up for the increase in overhead and the decrease in reimbursements. At some point though, will there be enough hours in a day for the physicians to keep up with the rising costs of practicing medicine and decreased reimbursements?

Another option for the physicians is to shift their patient loads away from lower paying insurance companies or to go to a totally cash pay office. This means that the patients would have to pay in full at the time of their visit and then can file their insurance claims on their own and receive the reimbursements from the insurance company instead of them going to the physician. In doing this, contracting with insurance companies would no longer be an issue because there would no longer be any contracts. Unfortunately for the patients, this would mean that their physician is an out of network physician which results in lower paid benefits and more out of pocket costs for the patient.

The option of cash pay would also allow the physicians to eliminate a large part of their overhead which is employee salaries. There would no longer be a need for a complete billing department or payment posting department since all payments would be received as the patients
leave the office. There would not be a need to re-file insurance claims or to dispute payments
made by the insurance companies because all of that process would now be left for the patients
to do.

In the cash pay scenario, the physicians and the insurance companies both come out as
winners at the expense of the patients. Many patients do not have the knowledge needed to file
their own insurance claims resulting in a large number of denials on the part of the insurance
companies. There will also be a percentage of patients that will not even try to file their own
insurance claims because it is too tedious and time consuming. For the insurance company this
means less claims paid out so their bottom line numbers increase. For the physicians, they are
getting paid in full for the services they performed. The patients though are paying for their visits
up front and may or may not be reimbursed for a portion of what they paid for their office visit,
but they are able to continue seeing their family physician.

The third option for physicians is to switch their practice to a concierge practice. This
means they will lessen their patient load and charge their patients a retainer fee each year to
continue seeing their family physician. In addition to this fee, the patients will also have to pay
office co-pays and the physician will file their claims with their insurance companies. In return
for the retainer fee, the patients will have little to no wait time in making an appointment, most
times getting in the same day or the next day for an appointment. The patients will get more one
on one time with the physician as well as more comprehensive care from their physician. Their
physician will coordinate their care with specialists as needed and be available around the clock.
The patients will even have access to the physician’s cell phone number.

For the physicians this means they can see far fewer patients in a day concentrating on
the quality of the care they provide instead of the quantity. They can get back to the reason they
started practicing medicine in the first place, to help their patients. And as an added bonus, they will be able to reduce some employee overhead because of the reduced number of patients they will be seeing on any given day.

*What does reduced insurance reimbursement mean for the patients?*

Many patients do not understand the concept of insurance reimbursements, insurance contracting, and contractual write-offs. As long as they do not receive a bill from their physician, they are happy. Patients have to educate themselves and get a better understanding of how their insurance companies pay for their office visits. Unfortunately, many patients have a misconstrued image of their physician in thinking that he or she makes a lot of money and lives in a big house. In reality, each year, physicians are making less and less money.

If the physicians decide to switch to a concierge practice, this means many patients that cannot afford to pay the annual retainer fee will be left without a primary care physician and may have a difficult time finding a new one. In this tough economic period, it is a constant struggle for some patients to determine what else has to be eliminated from the family budget as job cuts and layoffs continue. Concierge medicine could mean their medical care could become non-existent leading to a higher percentage of chronic illness is left unattended, which just leads to other medical conditions. Are patients willing to jeopardize their health by walking away from their primary care physician? Some patients will be forced to do this.

For patients that can afford to pay the annual retainer fee to keep their family physician, it means they will be more out of pocket expenses for their medical care. This price does have the benefit of better, higher quality of care from their physicians as well as greater access to their physician.
The patient’s attitude will determine if they feel the transition to a concierge practice is worth the extra money or not. Attitude plays a large part in the success of a concierge practice. An attitude represents a person’s general feeling about an object and is always held in high respect of the object. It also indicates the person’s passion toward the object (Werner & DeSimone, 2009). In this case it represents the patient’s strong desire to have the best care possible and what it will take to get that care.

Going hand in hand with attitude is behavior, or in this case consumer or patient behavior. The physicians have to determine what it is the patient’s want and then provide it for them. So for the patients that have paid the retainer fee for a concierge physician, the physician has to make sure the patients are getting what they want so it is a win-win situation for both (Kurtz, 2008).

There are many perceptions to the idea of a concierge practice. There are charges that concierge practices violate not financial ethics, but professional ethics. Others think concierge medicine creates a two-class system of medicine, one for the wealthy and another for the poor. Critics accuse physicians who make the transition to a concierge practice from a regular one abandoning their patients who cannot afford to join. Yet other critics feel that concierge medicine hurts the profession’s image, claiming the public is already mistrustful of doctors’ self interests and state that concierge practices exacerbate the distrust (Zuger, 2005).

Conclusion

Rising health care costs and reduced insurance reimbursements have left many physicians searching for alternatives to practicing medicine. Many physicians have already maxed out their patient load capacity and must find other solutions to continue generating revenue. Medicare is already continuing to cut reimbursements in the future and many commercial insurance
companies are slated to follow suit. This leaves physicians searching for solutions in order to continue practicing medicine. Physicians are puzzled at what the future of the healthcare industry looks like and how to get there.

Physicians enter the medical field to help people. The continuing mounds of paperwork and rising costs make it difficult for the physicians to give the patients the quality of care the patients and physicians want. There simply are not enough hours in the day to get it all done.

Recommendations

The physicians of the American Health Network office in Noblesville have several options to their current dilemma of questioning how to handle reduced insurance reimbursements. The most viable solution the author suggests is to begin the transition of several physicians to concierge medicine. The first step in this process is to begin to recruit at least one new physician to join the practice so that the patients that cannot afford the annual retainer fee or opt not to pay the annual retainer fee still have a family physician within the practice. The three physicians that will be making the switch have to decide among themselves if they will charge the same annual retainer fee or if they will individually determine their fees.

The other part of the equation is for the remaining physicians in the practice to begin shifting their patient loads away from lower paying insurance companies to better paying commercial payers. Unfortunately this means that the practice will no longer accept new patients with Medicare and Medicaid insurance and begin to limit the number of patients with Anthem insurance as well. Traditionally Anthem follows Medicare’s reimbursement guidelines, which puts them in the lower paying insurance companies.

The combination of these changes in the Noblesville practice will help to ensure that the physicians can generate more revenue allowing the practice to continue to grow and take care of
their existing patients. As the other physicians choose to change to concierge medicine, the cycle will continue; bringing on new physicians to help shift the patient load.

With this solution, the physicians are able to focus on the quality of care they are providing their patients instead of the number of patients they need to see in order to cover the overhead of keeping the practice open. It will enhance the level of care that is delivered to the patients and provide career satisfaction to the physicians.
References


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