

Compliance, Consolidation and Emerging Trends

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BACKGROUND

Undergrad: Business and Political Science.

Florida Senate Appropriations Committee: Community Care for the elderly.

1979. Masters in Business Administration – FSU.

1980 – 1984. Lobbyist: Florida Department of Health and Rehabilitative Services.

1987 – Present. Health law, transactions and compliance.

All of these experiences have led to this presentation.

WHY FEE FOR SERVICE?

THE MYTH OF FREE ENTERPRISE IN HEALTHCARE

Brief History of free enterprise and its principals

The English Empire and the Common Law.

Free and open competition.

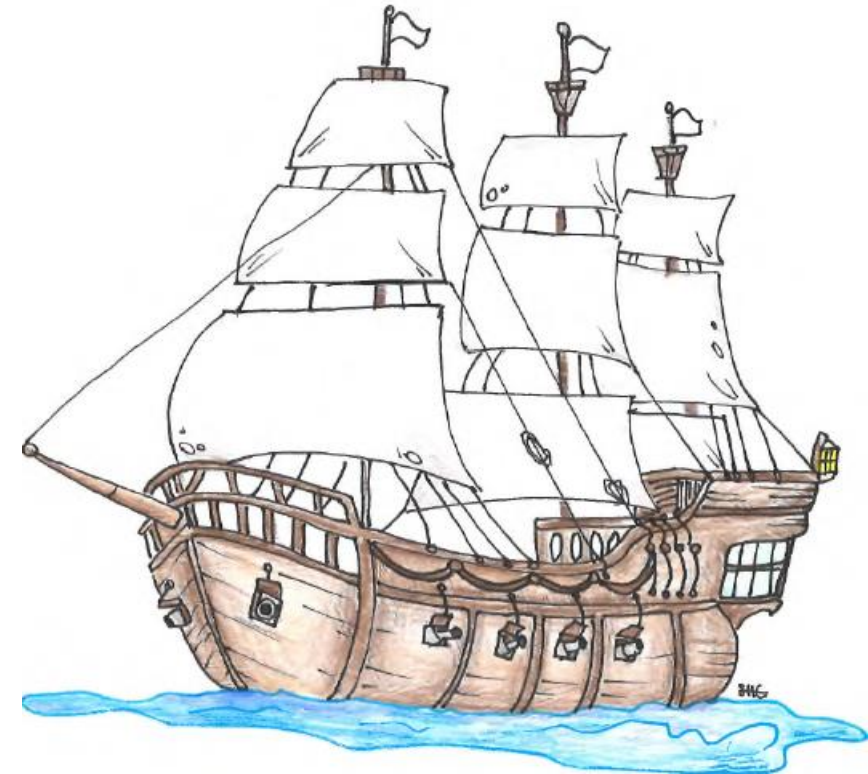
“Arm’s length transaction” between 2 parties.

Willing Seller **& Informed Buyer/Consumer**

Each acting in their own Enlightened

Self-Interest

Without duress. No compulsion to buy or sell.



Free Enterprise = Economic Incentives.

Pros: Harness the power of the individual. Rewards risk. Grows wealth exponentially.

Cons: Law of the jungle. Profitable ventures survive but essential but unprofitable services die.

FORM FOLLOWS FINANCE

(Follow the Money)

Before Insurance

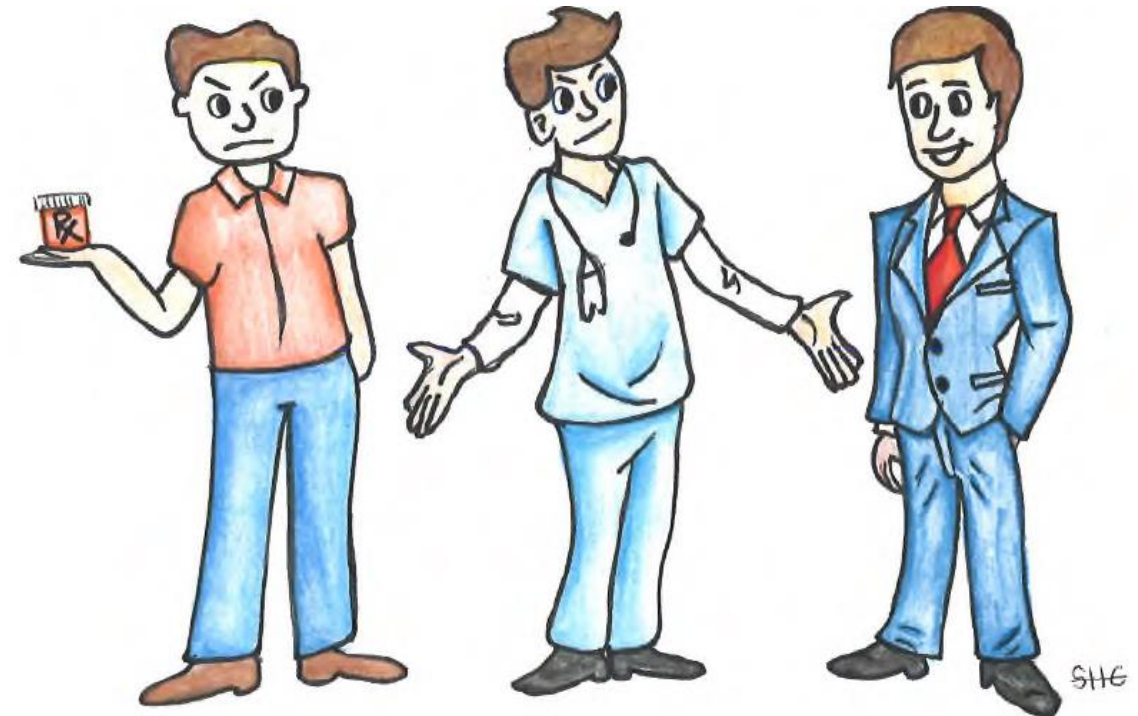
Two parties – Doctor and patient.
Form of payment – chickens and cash and house calls (Mostly, for the rich.)



AFTER INSURANCE

Three parties – Doctor, Insurance and Patient

Look whose in the middle?



Medicare and gradual expansion of employer based commercial health insurance and eventually some Medicaid for the poor.

What drives compliance under fee for service?

Action and Reaction.

Fear of overutilization: Concerns that economic incentives = medically unnecessary services and fraud.

Irony: Free enterprise/insurance = Fee for service.
 Free enterprise vs. National Health Insurance
 Fee for service = Fear of overutilization (Economic
 Incentives)
 Fear of overutilization = Compliance Regime

LAST 40 YEARS – CHASING OUR TAILS

Stark, Anti-Kickback, Compliance Rules, Pre-Authorizations and Audits.

Pete Stark and Clinical Lab Study.

NOW – Concern that economic incentives will influence decisions about care.

INDUSTRIALIZATION OF HEALTHCARE – THE FACTORY
MODEL OF PRODUCTION.

“SHARED SAVINGS.” BONUS FOR CONTROLLING THE
USE OF SPECIALISTS TO BONUS FOR CONTROLLING
THE TOTAL EXPENDITURES FOR PATIENTS WITH
CHRONIC CONDITIONS (MEDICARE DISADVANTAGE).

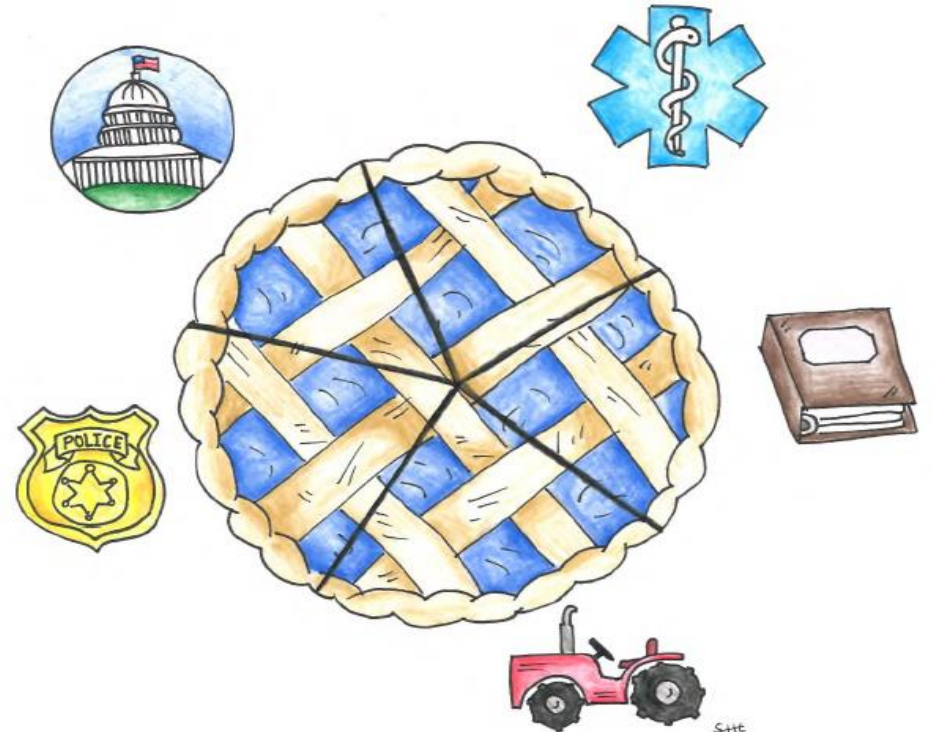
MORE ON WHAT HAPPENED & HOW DID WE GET HERE?

Limited Government Budgets. There's only so much to go around.

Insurance companies are expected to turn a profit.

Free Enterprise: The Corporation's Obligation to its Shareholders (Dividends).

Collection – Payments = Profit.



How to Maximize Profit – Speed up Collections and Slow Down Payments.

Limit covered services, add paperwork, request records, reduce or deny, discourage appeals.

INSURANCE: Complication for Profit.
 The devil is in the details.
 The devil **is** the details.

My Life as a Lobbyist

What are two things you don't want to watch being made...?

Laws and Sausage

Government as a Neutral.

Consumers – Government – Industry.

Five years and seven Chapters of Law.

Hospitals, Nursing Homes, Assisted Living
Facilities, Clinical Labs, Radiation Technology.



Government as an Interested Party.

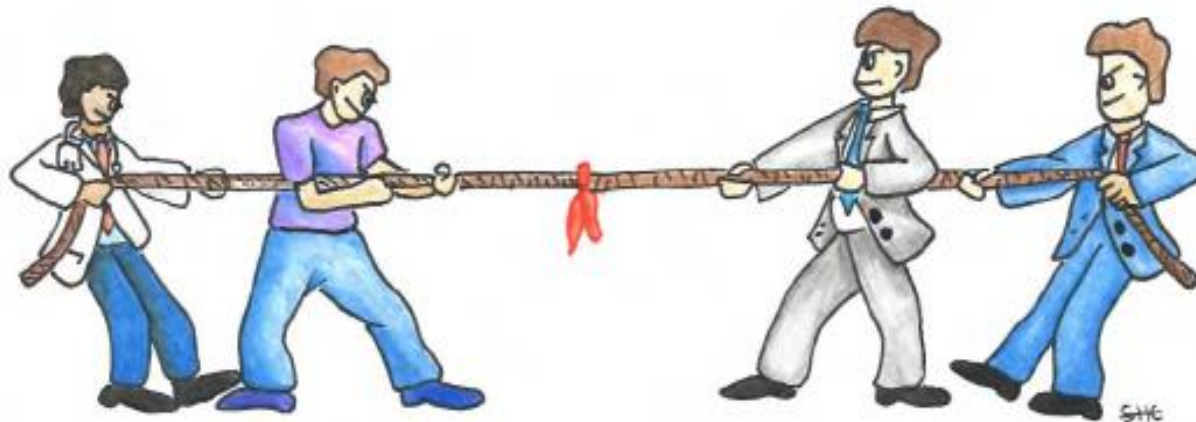
Government is a big employer

Government funds are limited.

Government and Insurance in Alignment.

Healthcare inflation – Double digits for 20+ years.

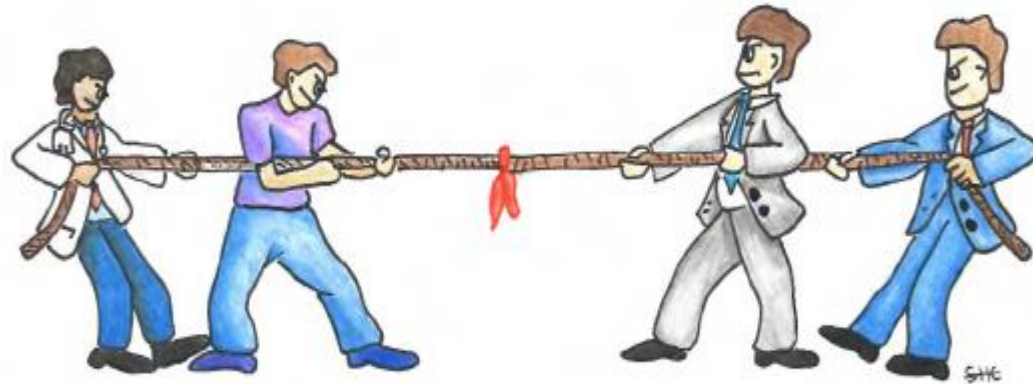
The powers that be – Government and Business were not going to tolerate it.



BUSINESS 101: What is the Key to a Successful Business Venture?

Alignment of Financial Incentives

Problem for Government and Insurance: Doctors and Patients are not in Alignment with the Government or Insurance.



40 YEARS OF DEVOLUTION

1980 – Managed care comes to Florida.

Why? Employers and Government in alignment.

Managed Care, Communism & Young Intellectuals.

The Theory of Managed Care: Harness economic incentives for “the good of the patient”. Capitated payments. Flat fee/month, regardless of care. Empower primary care. Incentivize preventive care and case management. Make primary care the gate keeper.

40 Years – Government seeking to control utilization with regulation.

40 Years - Insurance seeking Alignment with Doctors.

Like Marxism - Bait and Switch. Stalin never intended to share power and Insurers never intended to pay the doctor enough to make it work. Mice on the wheel. Assess, prescribe or refer to specialist.

Various types of managed care = Various forms of the carrot (Bonuses for controlling the use of specialists)
& Various Forms of the Stick: Audits & Recoupments.

Still – Healthcare Inflation continued unabated....

ACTION: 40 YEARS OF COMPLIANCE AND MANAGED CARE.

EFFORTS BY PAYORS TO CONTROL HEALTHCARE EXPENDITURES.

REACTION: 20 YEARS OF CONSOLIDATION BY PROVIDERS (HOSPITALS and PHYSICIANS.)

WHY DO DOCTOR'S NEED CONSOLIDATION? CLOUT.

Getting back to the “Arms-Length Transaction”

Willing Seller (Doctors) and Informed Buyers (Insurance).

Each acting in their own Enlightened Self-Interest.

Without Duress. No Compulsion to Buy or Sell. (Equals at the bargaining table.)

OPTIONS

Large physician owned groups. With professional management, CEOs, MBAs & CPAs.)

Pros: Controlled by Physicians.

Clout with Payors.

Stark exceptions for group practices & ancillary services (Lab, X-ray, PT, etc.).

In it for the long haul.

Cons: Group: Insufficient capital, takes time to grow.

Some “Alpha” doctors struggle with hiring, paying and delegating to professional managers.

Focus is on cost v expertise.

News Flash: The MD does not qualify you in all fields.

Notes: Employee Considerations.

Buy-In? Not for established practices.

Preferred formulas for the “founder

Founder ownership of the real estate.

Founder ownership of the management company.

HOSPITAL AFFILIATED PHYSICIAN GROUPS

Pros: Regular Paycheck.

Someone else “runs” the business.

Clout with Payors: (But to whose benefit?)

Cons: Employee: No longer in control. Hospital administrators “run” the business.

The “business” is the hospital.

In it for the long haul?

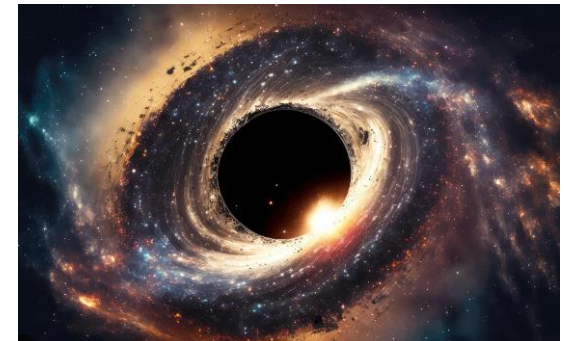
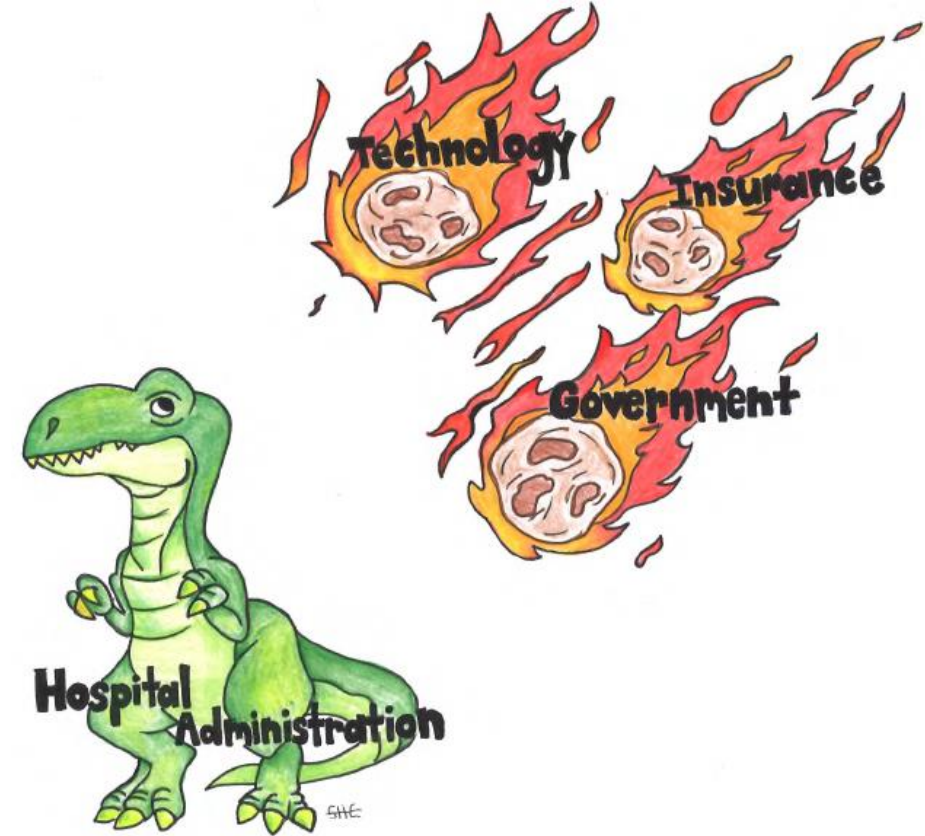
The hospital is a burning platform.

Compensation subject to change (FMV is a weapon).

Non-compete, non-solicitation, “ownership” of patients.

Slow to evolve/diversify (Can you say, “ASC”? Or “Group Practice”?).

Case study: Cleveland Clinic in Sarasota/Naples – Pulmonologist.



VENTURE CAPITAL FUNDED GROUPS

Pros: Big check up front.

Clout with payors: (This helps fund the initial big check and the promise of a greater wRVU payment, however, future benefit from growth will inure to the new owners and compensation rate locked in for a short period of time)

Cons: Loss of control to VENTURE CAPITALISTS

Non-compete agreements.

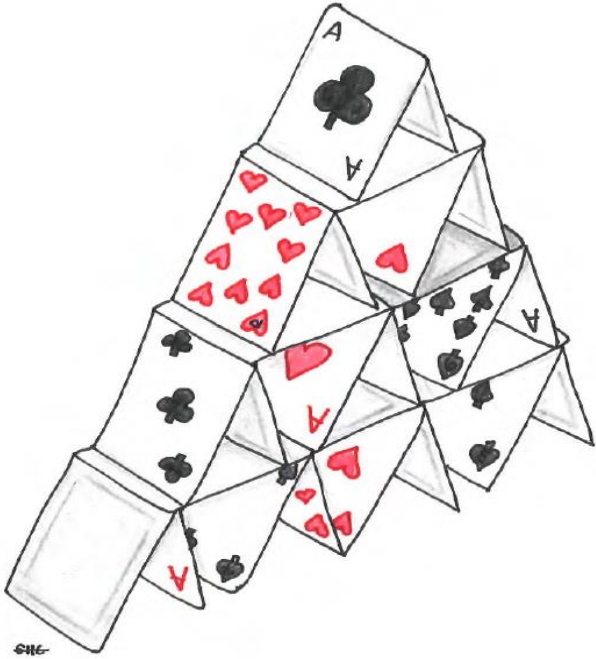
Bait and switch: Big check follow by clawbacks.

(You sold the business, you are no longer in control, but you still bear the risk of loss)

Old days: Caveat Emptor.



VENTURE CAPITAL FUNDED GROUPS - CONTINUED



AFTER THE SALE – NO ALIGNMENT OF INCENTIVES.

PRACTICES ARE LIKE BASEBALL CARDS.

GOAL: ASSEMBLE & SELL.

NO LONG TERM PLAN. 3-5 YEARS. ASSEMBLE AND FLIP.

STRATEGY: DRIVE DOWN COSTS, DRIVE UP EBITDA, FLIP FOR A MULTIPLE.

HIGHLY LEVERAGED ENTERPRISES – MORE DEBT WITH EACH FLIP. VULNERABLE TO CHANGES IN REIMBURSEMENT.

KEY ISSUES IN EMPLOYMENT AGREEMENTS

FMV – Get your own “independent” opinion. (Same is true for valuation of the practice.)

Non-Compete – The key to on-going power in a relationship. What is the “market”.

Non-Solicitation – Patient & referral sources (See state law).

“Personally rendered” services v APRN & “Incident to” collections.

Share of infusion profits? (Reserved for Partnership.)

MANAGEMENT SERVICE ORGANIZATION (“MSO”)

(BASIC ARRANGEMENT)

Pros: Professional Management, Billing and Collection Services, EMR, Assistance with negotiations with payor contracts.

Cons: Competency varies widely.

Without consolidation – still no Clout with Payors.

Notes: Negotiate the “unwind” up front.

What is the fee?

What is covered by the management fee?

In addition to the management fee, what costs are passed through to the practice?

What is the term?

Case Study: Phymatrix - 10 year term was a loan to the seller and an annuity to the next buyer.

MANAGEMENT SERVICE ORGANIZATION (ADVANCED MSO ARRANGEMENT)

Pros: Professional Management, Revenue Cycle Services, EMR, IT, HR, Training & Compliance

Professional Services Agreements & Single Tax ID # = Clout with Payors

Independent Contractor Agreements & No non-compete agreements. Doctors remain free to come and go.

No non-compete.

Cons: Lost of day-to-day control (but you never wanted to run the business anyway)

Dependent on the quality of management,

Pros: If structured properly, there is Alignment of Incentives.

As the business grows, everyone make more money.

No non-compete, if all else fails, you can leave.

Notes: Flat fees + % fees. (Get your own opinion of FMV.)

Monthly reporting: Aged AR, sample denials, write-offs.

Periodic 3rd party reviews of billing and collections and compliance issues.

Keep in mind: Physicians remain liable for recoupment.

Periodic 3rd party reviews of accounting.

WHAT ABOUT THE FUTURE?

THE FALSE CHOICE – CAPITALISM V. “SOCIALIZED MEDICINE”

(There is no free market, no arms-length transactions, no balance of power.)

DIFFERENT PAYOR MODELS

NATIONAL HEALTH INSURANCE?

Note: We're already paying for it...but we're not getting it.

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