TASK FORCE ON SURVIVAL OF INDEPENDENT PRACTICE

Thomas T. Lee, MD, Co-Chair
Paul Lograno, MD, Co-Chair

Meetings of November 19, 2015
December 10, 2015
January 14, 2016
February 17, 2016

Charge to the Task Force
The task force was charged with exploring options for independent physicians to collaborate and create practice models to achieve the goals of diversity of service, economy of scale and collective negotiations, examining models used in other states, and reporting its findings to the Council, which will develop a plan of action to preserve independent practice in New York State.

MSSNY President Joseph Maldonado, MD, instructed the chairs that the task force’s work product should identify real practical examples that have worked for independent practices.

Task Force Members

Rose Berkun, MD, (AN) Erie
Ellen Braunstein, MD, (NFUROL) Nassau
Henry Chen, MD, (IM) Kings
James Chmiel, MD, (OTO) Erie
Eli Einbinder, MD, (PSYCH) New York
John Franco, MD, (FP) Suffolk
Scot Glasberg, MD, (PS) New York
Michael Goldstein, MD, JD, (OPH) New York
Thomas Lee, MD, (NS) Westchester

Paul Lograno, MD, (OBG) Suffolk
Bing Lu, MD (IM), Kings
Donald Moore, MD, (GP) Kings
Hanna Ortiz, MD, (OBG) Suffolk
David Page, MD, (FM) Onondaga
Jack Resnick, MD, (IM) New York
Sumir Sahgal, MD, (IM) Bronx
Stephanie Siegrist, MD, (ORS) Monroe
Saulius Skeivys, MD, (FM) Queens

The task force co-chairs met with MSSNY staff in late October to discuss the meeting format and planned meeting schedules. The full task force met in November, December, January and February to review concepts put forward by members. Individuals from various parts of the state and in different specialties offered various approaches to making their practices more successful financially, or to free them from many of the administrative frustrations of practice.

Recognizing that members have varying degrees of willingness to collaborate, it was agreed that MSSNY should not only seek to advise on collaborative models of care, but also provide plans to help those who do not want to collaborate and remain completely independent. The task force recognizes that one size does not fit all. Some general recommendations are applicable to all physicians. Other recommendations may be more applicable to solo or small group practices, while others are more applicable to a larger single or multi-specialty setup. Members interested in these concepts are advised to perform their own due diligence. Many task force members have expressed willingness to share their experience and advice with MSSNY members.
Based on the above, and recognizing that there are likely to be formulas for success other than those we have reviewed, the task force recommends the following as potential avenues for members to consider. It should be noted that the practice models presented by the task force members are not specifically endorsed by the task force or by the MSSNY, and that they have not been subject to legal review. In the current environment, when physicians are beleaguered with rules dictating what they cannot do in practice, the task force wishes to offer examples of practice models that have been creative in exploring what can be done. They are offered as options for members to consider, modify or build on.

RECOMMENDATIONS FOR PHYSICIANS WHO WANT TO RETAIN THEIR OWN INDIVIDUAL PRACTICES

**A Hybrid Practice Model** *(See “Moving to a Hybrid Model – Direct Pay – Except for Medicare and Medicaid” By Donald Moore, MD, in the Appendix to this report)*

By eliminating commercial insurers whose fees are unacceptably low, primary care physicians can devote enough time to remaining patients to take advantage of added reimbursements from Medicare and Medicaid for the time-consuming elements of chronic care management. Physicians who choose to provide these extended services must document the actual time spent with the patient in order to defend themselves should they be singled out as outliers in RAC audits.

Maintaining quality of care is the key to patient engagement, which is the key to control of the system. The term “selective network participation” was suggested as an operating principle more physicians should consider.

Dr. Moore and Associates will be adding a house call option to its concierge service offerings for direct pay patients.

Physicians are advised that it is unlawful to offer direct pay or concierge arrangements for any services that are covered by plans or networks with which the physician participates.

**An Independence At Home Shared Savings Initiative** *(As described in “Statewide IPA for Dual Eligibles- Independence at Home”, by Jack Resnick, MD, in the Appendix)*

Independence At Home is an Obama Care pilot program focused on caring for chronically ill patients, especially those with several co-morbidities. Patients stay in traditional Medicare and physicians are paid on the usual fee-for-service basis, but they are incentivized by gain-sharing.

To participate, physicians must form an Independence at Home organization. Fee-for-service Medicare patients must identify it as their IAH provider and each patient has a personal physician whom they can reach 24 hours a day, seven days a week. Coverage must be supported by an EHR system. The goal is to reduce use of emergency rooms, hospitals and nursing homes.

If Medicare costs come in below projections, Medicare gets the first 5% of the savings. Physicians get 80% of the rest. There is no down-side risk. The ideal physician organization to form an IAH, according to Dr. Resnick, is an IPA. Medicare savings have averaged $3500 per year per patient, and far outweigh payments based on chronic care management codes.
There were some comments suggesting that EIMG might be considered a pseudo-group and come under antitrust scrutiny. Dr. Chmiel noted that the group seems to have taken many of the steps needed for a state Certificate of Public Advantage, and suggested that they might consider pursuing that protection.

**A Certificate of Public Advantage** *(See the COPA description by James Chmiel, MD, in the Appendix)*

Dr. Chmiel’s ENT group is currently awaiting a response from the NYS Department of Health on its application for a Certificate of Public Advantage, which would allow independent doctors with their own tax ID numbers to negotiate collectively, under very close scrutiny and strict rules for clinical integration, with immunity from state and federal civil and criminal action.

This “supergroup” model allows for all groups to maintain private finances, but to benefit from economies of scale. They pursue hospital contracts together and offer creative approaches to improving quality and reducing costs. It is a local approach funded and developed by the physicians participating in the group, using agreed-upon concepts for clinical integration with an emphasis on disease process/diagnosis management. Such an arrangement must, by nature, be local or regional, but other MSSNY members can benefit from information on the process, and what to anticipate in terms of application expenses, legal fees, and costs for consultants and staff to complete the lengthy application.

The task force voted to support the concept with the caveat that it is still in progress and has not yet been tested at the federal level. Decisions have been favorable so far, but a positive ruling is not guaranteed.

**FOR PHYSICIANS THINKING OF JOINING IPAs**

The task force recommends that MSSNY take a two-pronged approach to helping members who want to be part of an IPA.

1. Information is being compiled on IPAs in New York State so that members who want to affiliate can be made aware of options available to help with some of the business challenges of practice. It will include some basic information on how the IPAs operate and whether they are accepting new physicians. This should be an ongoing project that is updated periodically. *(See “IPAs in New York State” in the Appendix.)*

2. MSSNY should also pursue development of a statewide IPA for members.

**GENERAL RESOURCES**

**Entrepreneurial Coaching** *(See the “E-Myth Coaching Proposal” forwarded by Stephanie Siegrist, MD, in the Appendix)*

The E-Myth company offers free online course materials based on the series of best-selling business books, and a free introductory webinar. EMyth-certified coaches provide two one-hour live web or phone meetings each month and unlimited email support.
Reading Materials (See the list of EMyth books in the appendix.) MSSNY should make available a recommended reading list from the Entrepreneurial Myth library, and supplement it with additional suggestions as members become aware of the list and add to it.

Practice Management Companies (See information on Healthcare Transitions Management and PracticeMax in the Appendix) The two companies provide different degrees of assistance to respond to differing needs of members.

SUMMARY

RECOMMENDATIONS: The Task Force on Survival of Independent Practice makes the following recommendations for MSSNY Council approval (please refer to the Appendix for details):

1. That information on the following practice models be offered through the society’s website as options physicians might consider in order to retain their ability to practice successfully in an independent environment. All recommendations should include a legal disclaimer advising physicians that they should never enter any form of practice without legal guidance:

   a. A Hybrid Practice Model (“Moving to a Hybrid Model – Direct Pay (except for Medicare and Medicaid”)
   b. An Independence At Home Shared Savings Initiative
   c. A Practice Without Walls (“The Excelsior Integrated Medical Group”)
   d. A Certificate of Public Advantage (See COPA)

2. That MSSNY explain the potential benefits of Out of Network practice for physicians and provide mentoring by members who practice out of network to help those who are interested in pursuing this practice alternative.

3. That MSSNY maintain and publish information on IPAs in New York State so that members who want to affiliate can be made aware of options available to help with some of the business challenges of practice.


5. That MSSNY gather information on practice management companies offering varying degrees of assistance to members who want to be less involved in the business side of practice.

(FOR COUNCIL APPROVAL)
Primary care doctors are among the lowest paid in the healthcare industry, and over the years have experienced cuts to our bottom line, as insurers try to cap physician fees in order to control health care costs. When the Affordable Care Act (ACA), also known as Obamacare, went into full effect in 2014, insurance premiums skyrocketed, and paperwork required doubled which is costing private practices more time, money and manpower. In addition to being worn out from wrestling to get insurance reimbursements, as a primary-care doctor, I have always complained about having to see too many patients a day in order to cover my overhead because my reimbursements are based on these encounters.

Realizing that these changes were imminent, and to avoid this expensive and bloated bureaucracy that drives financial reimbursements, we made the decision in August 2012 to move to a single payer system effective January 1, 2013. We stopped accepting all commercial insurances and started accepting only Medicare and Medicaid Insurances (Single Payer). We also adopted a hybrid practice model that many now refer to as a form of “direct pay”. Using this model, we developed and implemented 2 payment plans for our non-Medicare and Medicaid patients who wanted to continue with the practice.

<table>
<thead>
<tr>
<th>PLAN #1</th>
<th>PLAN #2</th>
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<tbody>
<tr>
<td><strong>One (1)</strong> Annual Comprehensive Health</td>
<td><strong>One (1)</strong> Annual Comprehensive Health</td>
</tr>
<tr>
<td>Maintenance Visit</td>
<td>Maintenance Visit</td>
</tr>
<tr>
<td><strong>Three (3)</strong> Detailed Health Maintenance</td>
<td><strong>Three (3)</strong> Detailed Health Maintenance</td>
</tr>
<tr>
<td>Visits</td>
<td>Visits</td>
</tr>
<tr>
<td><strong>One (1)</strong> Urgent Care Visit</td>
<td><strong>Eight (8)</strong> Expanded Visits</td>
</tr>
<tr>
<td>(Plan covers 5 Visits within a 12 month period)</td>
<td>(Plan covers 13 Visits within a 12 month</td>
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<td></td>
<td>period)</td>
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<tr>
<td><strong>Savings</strong></td>
<td><strong>Savings</strong></td>
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<tr>
<td>Calculated savings of $250 compared to equal</td>
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<tr>
<td>services outside of membership plan.</td>
<td>Calculated savings of $500 compared to equal</td>
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<td></td>
<td>services outside of membership plan.</td>
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<tr>
<td><strong>Terms of Payment</strong></td>
<td><strong>Terms of Payment</strong></td>
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<tr>
<td>Initial payment 5 monthly payments.</td>
<td>Initial payment and 5 monthly payments.</td>
</tr>
<tr>
<td>Price does not include the cost of diagnostic tests.</td>
<td>Price does not include the cost of diagnostic tests.</td>
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</table>

We devised a blueprint for executing our new business model:

1. Cap the number of patients seen weekly at 75.
2. The Physician works 32.5 hours per week sees approximately 1.5 patients per hour.
3. Give adequate time and attention to each patient (minimum 30 minutes) which allows for counseling and education on living a better life, changing behaviors and getting patients to adopt more healthy lifestyles. The table below shows the new face-to-face interaction time with each patient (Medicare, Medicaid & Self Pay Patients):
### OFFICE VISIT

<table>
<thead>
<tr>
<th>OFFICE VISIT</th>
<th>PRICE</th>
<th>TIME</th>
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<tbody>
<tr>
<td>Detailed Visit</td>
<td></td>
<td>30 Minutes</td>
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<tr>
<td>Expanded Visit</td>
<td></td>
<td>20 Minutes</td>
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<tr>
<td>Focused Visit</td>
<td></td>
<td>15 Minutes</td>
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<tr>
<td>Brief Visit/Adm. Services</td>
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<tr>
<td>Initial Detailed Visit</td>
<td></td>
<td>60 Minutes</td>
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<tr>
<td>Initial Detailed Visit (Includes: V/NS, SG, Finger stick (CS), Pulse oximetry)</td>
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<tr>
<td>Initial Expanded</td>
<td></td>
<td>45 Minutes</td>
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<tr>
<td>Initial Expanded (Physical Exam Only)</td>
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<tr>
<td>Comprehensive</td>
<td></td>
<td>60 Minutes</td>
</tr>
<tr>
<td>Comprehensive (Includes: V/NS, SG, Finger stick (CS), Pulse oximetry)</td>
<td></td>
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<tr>
<td>Annual Physical Exam</td>
<td></td>
<td>60 Minutes</td>
</tr>
<tr>
<td>Annual Physical Exam (Includes: V/NS, SG, Finger stick (CS), Pulse oximetry)</td>
<td></td>
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<tr>
<td>Comprehensive Annual Physical</td>
<td></td>
<td>60 Minutes</td>
</tr>
<tr>
<td>Comprehensive Annual Physical (Includes: V/NS, SG, Finger stick (CS), Pulse oximetry)</td>
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### Teleweb Consultation

<table>
<thead>
<tr>
<th>TIME</th>
<th>PRICE</th>
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<tbody>
<tr>
<td>Up to 15 Minutes</td>
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<tr>
<td>Up to 30 Minutes</td>
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<tr>
<td>Up to 60 Minutes</td>
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</table>

### HOUSE CALL

<table>
<thead>
<tr>
<th>TIME</th>
<th>PRICE</th>
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</thead>
<tbody>
<tr>
<td>Initial House call Visit</td>
<td>60 Minutes</td>
</tr>
<tr>
<td>Established House call</td>
<td>30 Minutes</td>
</tr>
</tbody>
</table>

### PROCEDURES

- EKG not included in initial visits
- Spirometry
- Post Bronchodilator Spirometry
- Arterial Puncture
- Venipuncture
- Physician Applied Venipuncture
- Stool Guaiac
- Finger stick (CS)
- Urine analysis
- Strep Test
- PPD
- Administrative Service

4. Identified new billable opportunities which improved on the levels of visit provided under the new model:

<table>
<thead>
<tr>
<th>Old Model - Billable Treatment Opportunities</th>
<th>CPT</th>
<th>Medicare Fee Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Insurance, Medicare, Medicaid &amp; Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detailed Visit</td>
<td>99214</td>
<td></td>
</tr>
<tr>
<td>EKG</td>
<td>93000</td>
<td></td>
</tr>
<tr>
<td>Spirometry</td>
<td>94010</td>
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<tr>
<td>Hospital Visits</td>
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<tr>
<td>House call Visits</td>
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<table>
<thead>
<tr>
<th>New Model - Billable Treatment Opportunities</th>
<th>CPT</th>
<th>Medicare Fee Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare, Medicaid &amp; Self Pay Patients</td>
<td></td>
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</tr>
<tr>
<td>Detailed Visit</td>
<td>99214</td>
<td></td>
</tr>
<tr>
<td>Weight Counseling</td>
<td>G0447</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>99407</td>
<td></td>
</tr>
<tr>
<td>Initial Annual Wellness</td>
<td>G0438</td>
<td></td>
</tr>
<tr>
<td>Subsequent Annual Wellness</td>
<td>G0439</td>
<td></td>
</tr>
<tr>
<td>Welcome to MCR Exam</td>
<td>G0402</td>
<td></td>
</tr>
<tr>
<td>Alcohol Screening</td>
<td>G0442</td>
<td></td>
</tr>
<tr>
<td>Cardio Vascular Screen</td>
<td>G0446</td>
<td></td>
</tr>
<tr>
<td>Annual Depression Screen</td>
<td>G0444</td>
<td></td>
</tr>
<tr>
<td>Hospital Visits</td>
<td></td>
<td></td>
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<tr>
<td>House Call Visits</td>
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</tbody>
</table>

The practice saw a 75% decrease in patient count in the first year. Since we were seeing fewer patients we had the opportunity to lease the unused office space to another physician thus covering a part of the monthly overhead and also maintaining our current staff to provide coverage for this Physician.

21
The practice is now two years into this new model and as a physician I can now spend more time on each patient visit, focusing entirely on caring for my patient’s needs, offer more same-day appointments, and get to know my patients very well. I no longer feel a need to run from room to room, seeing patients on a tight schedule, just to maintain a stable revenues structure for the practice. I now see only 75 patients per week and the practice is projected to make a profit in 2015.

House Call Services
Dr Moore and Associates House Call Services provides comprehensive, personalized, compassionate and skilled primary health care services to elders in the comfort of their homes. Our In-home medical care allows for proactive management of chronic health conditions that would otherwise result in costly emergency care and hospital admissions. Our main goal is to monitor patients at home and identify illness before it becomes acute or require a visit to the emergency room.

Effective March 1, 2016, the practice will implement its house call concierge plan. House call visits will only be available to patients enrolled in our Concierge medical service. We have established two payment options for this plan. Patients can either pay the total amount upfront or make 10 monthly payments. Patients will receive a discount in the first year. The services in this concierge Plan will include the following:

1. Housecall visits*
2. Teleweb consultations*
3. 24 hour physician access

*As needed.

We will continue to accept assignment for our Medicare patients. The patient will still be responsible for the amounts not covered by their insurance (deductibles and coinsurance). Medicare reimburses 80% of our physician’s professional fee, once the annual deductible is met. Many supplemental insurance plans pay the remaining 20% of the physician’s fee, and some plans cover the patient’s annual deductible.

Summary of Changes

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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</thead>
<tbody>
<tr>
<td>August 2012</td>
<td>Made decision to discontinue contracts with commercial insurance companies</td>
</tr>
<tr>
<td>September 2012</td>
<td>Developed payment plans for the new practice model.</td>
</tr>
<tr>
<td>September 2012</td>
<td>Provided 3 month notice to Commercial Insurance companies to leave the network effective January 1 2013.</td>
</tr>
<tr>
<td>September 2012</td>
<td>Sent letters to patients informing them of the decision to stop accepting commercial insurances effective January 1 2013.</td>
</tr>
<tr>
<td>December 2012</td>
<td>Revised Office schedule and Visit Times</td>
</tr>
<tr>
<td>August -December 2012</td>
<td>Identified new billable treating opportunities and incentives. (Welcome to Medicare, Annual wellness Visits etc.)</td>
</tr>
<tr>
<td>January 2013</td>
<td>Implemented new Practice Model</td>
</tr>
<tr>
<td>April 2013</td>
<td>Leased underused space in the office to another physician</td>
</tr>
<tr>
<td>2011 - 2014</td>
<td>Participated in CMS Incentive Programs</td>
</tr>
<tr>
<td>January 2015</td>
<td>Introduced the newly payable chronic care management (CCM) service to all Medicare Fee-For-Service Patients.</td>
</tr>
<tr>
<td>March 2016 (New)</td>
<td>Implementation of house call concierge plan.</td>
</tr>
</tbody>
</table>
IMPORTANT NOTE FROM THE OFFICE OF INSPECTOR GENERAL: Medicare participating physicians may not bill Medicare patients extra for services that are already covered by Medicare. Doing so is a violation of a physician’s assignment agreement and can lead to penalties.

WITH REGARD TO BOUTIQUE OR CONCierge PRACTICES:
If you are a participating or non-participating physician, you may not ask Medicare patients to pay a second time for services for which Medicare has already paid. It is legal to charge patients for services that are not covered by Medicare. However, charging an “access fee” or “administrative fee” that simply allows them to obtain Medicare-covered services from your practice constitutes double billing. Excluded providers may not receive Medicare payment either as participating or non-participating providers.

NYACP
Task Force on Independent Practice

Jack Resnick, M.D.
JackResnick@gmail.com

Internists in independent practice are uniquely positioned to benefit from the movement to value based payment to physicians.

1. we often have closer relationships with our patients than our employed physician colleagues
2. our personal availability is usually better than that provided by physicians who work for institutions
3. we can refer freely to specialists and institutions in our community without concern for their organizational affiliations
4. these factors contribute to higher quality and lower cost

There is strong data to support these statements from the Obamacare demonstration projects. Gain-sharing relationships with our patients’ insurers -- commercial or governmental -- can produce significant increases in our revenues.

Pilot for a Statewide IPA for Dual Eligibles

A proposal for the Independent Practice Committee of the NY ACP

Dual Eligibles (individuals covered by both Medicare and Medicaid) are the sickest and costliest to care for. A Federal/State program initiated earlier this year -- Fully Integrated Duals Advantage (FIDA) to address these beneficiaries failed miserably across the country. We have been working with senior administrators in Albany and Washington on this issue.

FIDA failed because it relied on insurance companies and their restrictive networks to provide the health care. Beneficiaries with multiple comorbidities and long-term relationships with their doctors opted out of the FIDA plans -- and appropriately so. These are the last people who should be forced to break continuity.

Almost simultaneously, another CMS program -- Independence at Home (IAH) -- finished its three-year demonstration with resounding success. Ten thousand Medicare beneficiaries in 17 sites spread around the
country scored high on clinical and satisfaction metrics - and saved more money than any other Obamacare project. It has been renewed by Congress and the President for another two years.

IAH is a very simple program.
1. There are no networks.
2. There is no prior approval for services.
3. Patients stay in traditional Medicare and physicians are paid in the usual fee-for-service process.
4. Every IAH patient has a personal physician whom they can reach 24/7.
5. Physicians are incentivized by gain sharing -- if Medicare costs come in below projections, Medicare gets the first 5% of the savings. Physicians get 80% of the rest.
6. There is no down-side risk.
7. The ideal physician organization to form an IAH is an independent practice association (IPA)

Combining IAH with a managed-long-term-care plan would provide the infrastructure to keep these vulnerable people out of institutions and care for them at home. It also saves enormous amounts of money.

RECOMMENDATIONS ON OUT OF NETWORK

Eli Einbinder, MD
einbinder@aol.com

1. MSSNY should let members know that Out of Network practice may be an option for them to consider.
2. MSSNY should let members know that Out of Network practice viability strengthens in-network and hospital employee bargaining power.
3. MSSNY should also consider offering mentoring by MSSNY members, and consider including some who also belong to the Independent Doctors of New York* and the Out of Network Preservation Group* as a potential source of information on Out of Network practice for members.

*Independent Doctors of New York is a group of 120 completely Out of Network physicians supportive of one another and the idea of expanding traditional medical practice.

*The Out of Network Preservation Group was originated to support those maintaining Out of Network practices. Initial goals included coverage and a possible PR campaign to educate patients about diminishing free choice of physicians. It has since identified many other helpful tasks its members can perform for one another.

The group has more than 300 members, six co-chairs and a steering committee of approximately 20 members.
OUT OF NETWORK

THE CHALLENGE TO EDUCATE: D.A.R.E.

Hannah Ortiz, MD
drortiz@soundgynonc.com

1. **Define:** It is the responsibility of MSSNY to **define** what it means to be "out of network." Physicians need to understand that non-participation is an option. This should be done in at least two simplified formats (trifold fold mailing and email) circulated to members and non-members alike. This would also be an excellent recruitment tool and potentially recoup lost revenues from frustrated physicians who have opted out of MSSNY membership.

2. **Alert:** Part of the definition should **alert** physicians of the potential for improved income for those who are out of network. More importantly, it provides a bargaining chip for those in-network physicians negotiating contracts with insurers. Absence of the out-of-network option as a bargaining chip translates into insurers effectively transforming physicians into lemmings, happily jumping off a cliff to their financial demise as less educated and talented people continue to augment their revenues at physicians’ expense.

3. **Reject:** MSSNY and non-MSSNY members alike need have the courage and understanding to **reject** low-revenue models through non-participation. Defining the terms, alerting physicians to the negotiating power of non-participation are the first two steps. Rejection of the in-network model is the third step, but it requires support and education.

4. **Educate:** Implied in the challenge to **educate** is the responsibility of MSSNY to provide committed one-on-one mentorship to physicians who elect to go out of network and seek guidance through the process. This should include telephone or online support from mentors, recommendations on out of network models (e.g. IPA), billing and collection services, EMR ideas, financing options, among others. The Out of Network Preservation Group can grow into such a mentorship model.
INTRODUCTION OF EXCELSIOR INTEGRATED MEDICAL GROUP PLLC (EIMG)

Henry Chen, MD
HChen@jennanmedical.com

Organization: Excelsior Integrated Medical Group PLLC, a New York professional limited liability company ("EIMG"), is a clinically and financially integrated medical group that qualifies as a group practice (for purposes of the federal anti-referral prohibition, known as the Stark law), is governed by a centralized board, yet provides a meaningful level of autonomy to its operating divisions to operate efficiently and harmoniously.

EIMG considers itself a group practice without walls formed to share economic risk and administrative costs (for example, one accounting firm and law firm, one banking and benefits coordinator relationship, consolidated billing, marketing services, and group purchasing, etc.), establish ancillary services and business lines, gain access to capital and credit necessary to facilitate expansion, secure executive level resources, and apportion the cost of necessary infrastructure, equipment and technology to facilitate the delivery of quality, cost-effective medical services.

Mission: EIMG was formed in 2013 to be a clinically and financially integrated, multi-specialty medical practice comprised of primary care physicians and physician specialists in Manhattan, Brooklyn, and Queens, with a substantial focus in Chinatown, Sunset Park, and Flushing.

To address healthcare reform, EIMG has, as one of its threshold initiatives, committed itself and its affiliated physicians to value based medical care delivery, by enabling its physicians to share information, manage patient outcomes more effectively, collaborate to promote quality assurance, while, importantly, allowing its affiliated physicians to maintain a level of autonomy through the operation of their divisions in their prior practice settings utilizing their prior practice employees.

As part of its practice without walls initiative, EIMG operates its own laboratory, diagnostic imaging center, and seeks to procure equipment and office space that can be shared by its affiliated physicians. Importantly, EIMG is committed to corporate compliance and quality assurance, and has established committees to oversee both functions.

Structure and Governance: EIMG is a unified and centralized business for purposes of governance and management, including, without limitation, (a) centralized decision-making by a managerial body that maintains effective control over EIMG’s affairs and business operations, and quality assurance protocols and policies, and (b) consolidated billing, accounting and financial reporting. EIMG’s managerial body (the “Board”) possesses the authority to establish the overall business policy and direction of EIMG.

Establishment and Operation of Divisions: EIMG’s economic and operating model is the cost and revenue center model (each a “Division”). In this respect, each Division operates as a distinct cost center whereby income generated by the physicians affiliated with a Division, and the costs and expenses incurred by such Division, generally stay with such Division. Specifically, operational decisions internal to a Division that do not affect EIMG as a whole, will be determined by the physicians associated with that Division, subject to (compliance with applicable law) and final approval of the Board.

At present time, EIMG has over 25 PCP and physician extendors, 10 specialists, 10 divisions, 9 primary care sites, 6 other specialty sites including cardiology division, lab division, diagnostic imaging center, house call division,
and Physical therapy division, and covers over 30,000 lives, including over 100 very frail, home bound patients, in the New York Metro-area. All our PCP and primary care sites are certified Patient Center Medical Home (PCMH) level 3 and Diabetes Recognition by NCQA and DOH of State of New York.

Additional EIMG owners will be added from time to time in phases as appropriate candidates are identified.

**Corporate Documentation:** The documentation necessary to operate EIMG and facilitate the inclusion of new physicians is as follows: (a) the Operating Agreement among all EIMG members sets forth the terms and conditions under which EIMG operates and conducts its business; (b) License and Administrative Services Agreement between EIMG and each predecessor practice entity; (c) a Subscription Agreement between EIMG and each member to enable each member to purchase an equity interest in EIMG; and (d) other ancillary documents reasonably determined by EIMG’s legal and business advisors necessary to facilitate the inclusion of new physicians.
Our group of ENTs has explored mechanisms to integrate, and improve care and our professional lives for greater than a decade. We felt that the best model was complete financial integration, but, our doctors were doing well at the time and did not want to give up their independence.

We explored IPAs- (multi-group and single specialty). Multi-specialty IPAs were prone to cronyism and often lead to squabbles over some physicians holding more water than others. So some physicians were not too excited to sign-on. Single specialty IPAs were expensive, suffered from the weakness of the messenger model, and the physicians were sometimes difficult to motivate even when a good thing was staring them in the face. Our group—ENTOCS- organically grew from a handshake agreement to cover ‘after hours’ call for each other, to a formal LLC, and finally to a Clinically Integrated PLLC. We studied the writings of the FTC. We also studied clinical Integration and brainstormed ideas on how we could improve care and cut costs. We were about to submit our case to the FTC for a summary opinion, when the concept of a NY State Certificate of Public Advantage (COPA) came along.

The COPA application was made available in December 2014. We did not find out about it until late January, 2015. The application was painful to fill out and the application process was expensive. Thankfully, we already had done most of the conceptual work. We also had a well thought out legal framework and, finally, had doctors motivated to participate. Of note, we demoted some doctors we thought were not likely to participate. We completed the application in late July/ early August, 2015. The application collected dust for a while at the DOH. We are happy to report that the application is now actively under review by the DOH. I’m not going to publish our contacts now because we are at a sensitive point in the application process. I don’t want my participation on this task force to injure our application. However, I am willing to discuss the names with you verbally.

HOW IT RELATES TO DISEASE PROCESS MANAGEMENT AND COLLECTIVE NEGOTIATION

1. To paraphrase fellow task force member John Franco MD, --if you’re not doing Clinical Integration, you need to be.
2. We as physicians all intuitively know how to improve care and cut costs, we just don’t have the time, the money or the business skills to take great ideas and bring them to fruition. Clinical Integration is a legal framework that allows pooling resources, collective negotiation, economies of scale, and the ability to reward physician participation in care that benefits the community. We presented 30 ideas with a plan to cherry pick the best ideas and implement about 3 per year over 5 years.
3. A COPA provides state action antitrust immunity from civil and criminal prosecution and does not suffer the weakness of the messenger model.
4. Washington DC Antitrust attorney Roberto Castillo said it best in an article published in Bureau of National Affairs Health Law Reporter (2015) “state certification… may deter FTC action to a certain extent. The more onerous and robust the certification scheme and state supervision, the likelier the FTC is to leave investigation and enforcement to the state. Such is the case with New York’s new COPA regulations, which appear to be quite rigorous.”
IPAs IN NEW YORK STATE

MSSNY is working through county medical societies to gather information on IPAs for members seeking to affiliate. We will update this information as additional reports are received.

BRONX
CORINTHIAN MEDICAL IPA
Ramon Tallaj M.D., Chairman of the Board

- Size – over 1200 physician members and over 300,000 patients
- Longevity – began in 1999
- Model-
  - Degree of physician involvement --Owned and managed by practicing community providers
- Degree of shared risk contracts
- Accepting new members—yes

For enrollments packets, physicians should call 1-877-MD-CMIPA.

Corinthian Medical IPA has contracts with the following Managed Care and Commercial insurance plans. Member physicians can request to participate in any or all of the contracts.

- Access Medicare NY
- Affinity Health Plan
- Alfa Care
- Amerigroup
- Elder Plan
- Empire
- Fidelis Care
- Health First
- Hip
- Metro Plus
- United Health Providers
- VNSWellCar

The IPA handles contract negotiations with insurers and managed care organizations, and provides a professional managed infrastructure, guidance and direction to improve physician practices.

BUFFALO
Catholic Medical Partners
Michael Edbauer, DO
716-862-1260

- Size – 986 Physician Members
- Longevity – Established in 1996
- Messenger model vs Clinically vs Financially integrated - Clinical
- Degree of physician involvement - almost totally physician led; CEO as of 1/1/16 is a physician; All Committees are chaired by a physician, with physician volunteers/appointees
- Degree of shared-risk contracts – Approximately 50%
- Willingness to accept new members – Open/accepting

MONROE
GRIPA (Greater Rochester IPA)
Joseph Vasile MD, Administrator
joseph.vasile@rochesterregional.org
• Size-1231 physicians belong to GRIP
• Longevity-GRIP was formed in 1996 and is associated with Rochester Regional Health
• Model-GRIP is clinically integrated
  Degree of physician involvement- works closely with the Rochester General Physician Organization. GRIP also participates on several MCMC Committees including the MCMS Quality Collaborative.
• Degree of shared risk contracts- All contracts are believed to include shared-risk. Needs confirmation.
• Accepting new members...as long as they are not part of the other IPA in town... Administrator-

AHP (Accountable Health Partners)
Robert McCann MD, Administrator
robert_mccann@urmc.rochester.edu

• Size 1800 physicians.
• Longevity-formed in 2013
• Model-Clinically integrated
• Degree of physician involvement-physician board comprised of independent and employed physicians. AHP participates on several MCMS Committees including the MCMS Quality Collaborative.
• Degree of shared risk contracts. All contracts are believed to be shared risk..
• Accepting new members-Specialists-it depends. They have started to turn physicians down. PCP-as long as they are not members of the other IPA in town.

A group of nursing homes in Monroe is also seriously considering forming an IPA.

NASSAU-SUFFOLK
The IPA of Nassau Suffolk Counties, Inc.
Frank DiMotta, COO, CHCO
ipasuffolkcounty@gmail.com

• Not for Profit,
• Size- 800+ members (200 PCPs),
• Longevity- Established in 2011
• Model- Messenger Model
• Degree of physician involvement-
• Degree of shared risk contracts..
• Accepting new members.
• Dues for PCPs -- $0.00
• Dues for Specialists -- $3,000.00; Multi-provider group discounts available
• Two enhanced contracts:
  a. BC/BS with shared savings
  b. Aetna
• Managed by "Practice Management of America" (a management service organization owned & operated entirely by physician members of the IPA)
• GPO – Savings
• Medical Malpractice Insurance Savings
WESTCHESTER
Hudson Doctors IPA and WMSO LLC
Anthony G. Demetracopoulos, MBA/JD
Executive Director and General Counsel
DemetracopoujosA@hdocsipa.com

• Size approximately 870 providers, including about 22 mid-level and 17 other non-MD providers.
• Longevity - In business for 20 years; started in September 1996
• Messenger model vs Clinically vs Financially integrated – Messenger Model
• Degree of physician involvement - All Officers are Physicians, 10 are Board Members and 6 are on the Credentials Committee.
• Degree of shared-risk contracts None, one in process of development
• Accepting new members
ENTREPRENEURIAL BUSINESS COACHING
Krista Bleich, Certified EMyth Business Coach

Brought to the Task Force by Stephanie Siegrist, MD
ssiegrist@knowyourbones.com

There is a way that you can preserve your independent medical practice. Dr. Stephanie Siegrist is an excellent example of what’s possible when you remain independent— and EMyth coaching helped get her where she is today.

10 years ago she stumbled upon EMyth as a coaching company to help her start to work on her business. The light bulb went off that she could build herself a practice that she was proud of as she learned the business systems she needed to put into place that would help her success.

In medical school you were taught how to be doctors, and now you are trying to run a business without a roadmap. It is a daunting task at best, especially without help or guidance. EMyth has been around for 40 years helping people like you to build successful business.

I understand that your time is limited, so I’ am happy to share our free online course materials with you. You can access these courses here: https://emyth.com/courses. While it’s great content, it is limited in scope as how it can really help you to change. Working with a coach enables you to capitalize on, and stay accountable to the processes that will help you meet your business goals.

Let me ask you this each individually. What is it that you want for your practice? What is it you want for your patients? What is it that you want for your life?

Next steps you can take:

- Learn more about how the EMyth Perspective can help you keep or grow your practice with a free 1 ½ hour Introduction to EMyth Coaching webinar. You can schedule this as a group.

- Want to get right into it? Schedule a free consultation with me to talk about your goals, identify what’s in your way, and work on a plan to build the independent practice you want.
THE E-MYTH PHYSICIAN

Michael E. Gerber

Available in: Paperback, Digital eBook, Audio Compact Disc Copyright © 2003

Book Description: Publication Date: January 6, 2003 Michael E. Gerber, bestselling author of The E-Myth Revisited shares his powerful insights to lead independent physicians to successful practices and enriched lives. Michael Gerber has dedicated much of his professional life to the study of entrepreneurship and business dynamics. His E-Myth Academy is renown in the entrepreneurial world for its business insight and guidance as well as its inspirational advice. In The E-Myth Physician, bestselling author Gerber returns to his roots in order to provide indispensable advice to doctors who own and run their own practices. Gerber provides excellent business insights into topics such as streamlining systems, effective small-business management practices, healthy patient relations and managing cash flow, all with the goal of freeing physicians from the daily grind of running a business and leading them to a happier and more productive life while doing the job they love-practicing medicine.
HEALTHCARE TRANSITIONS MANAGEMENT

HTM provides services to physicians on 3 different levels:

1. Outsourced billing- Outsourced billing is available in 2 models with practice level customization available in both of them. In the first more common model, we do the billing on our system. The client sends us the source documentation either on paper or electronically. The practice forwards the EOBs and all billing correspondence. We manage the Account Receivables and provide monthly reports. We meet with our clients every month. Based on a number of variables this is priced for each practice on a series of transaction rates with a percentage of collections cap (maximum). In the second model, we utilize their existing Practice Management software and manage it remotely from our location.

2. Consulting- Consulting services are customized for the need of the client. They can encompass anything on the business side of the practice ranging from a full assessment which may cost between $4000 and $10000 (depending on practice size and complexity) to a very specific task priced on an hourly basis at $125 per hour. Each consulting engagement starts with a customized proposal.

3. Practice Management- In this model clients retain HTM to work with full time staff in managing the practice. This is priced on a retainer basis dependent on the needs of the client.
Mr. Johnson was the Executive Director of Nevada Hotel association a few years ago and has some experience with what professional associations are looking for.

It is a national company with HQ in Scottsdale Arizona with a NY State office in Brewster, NY (Putnam County). It services the provider industry including physician practices. Two primary lines of services include practice/facility revenue cycle management and marketing/patient engagement. They provide the usual billing and collection services, claim revenue, claim coding, coding review, data analysis, financial reporting, and compliance. The second major piece is their patient communication platform and customer satisfaction tools, which could be helpful for practice growth/expansion and improve online presence of physician practices. They have some innovative concept on patient satisfaction and online feedback.

Total costs quoted for the entire revenue cycle services is 6-9% for surgical practices and 7-12% for medical practices. The exact amount would depend on EHR hosting and range of services desired. They have capability of hosting ECW and Nextgen EHR, or remotely accessing physician office EHR for billing. The marketing piece is a la carte (negotiable obviously: with $6-12k upfront and $500 monthly fee), and could include new/renewed website with patient communication, patient reminder/holiday greeting, patient satisfaction surveys and uploaded reviews of (for example) above 4 stars to be transmitted to RateMD, HealthGrade, etc, as well communication with referring physicians for marketing purposes.

We also discussed some association model which could potentially be tailored to MSSNY membership to add value to our members: discounted marketing/online presence/patient engagement vs free compliance training vs free coding review of 100 charts to optimize billing and ascertaining compliance. There is room for discussion here.