CSRO

COALITION OF STATE RHEUMATOLOGY ORGANIZATIONS

Realities of Private Practice

PRESENTER

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Homage…

- Herbert Baraf MD, FACP, MACR
  - Immediate Past Managing Partner, Arthritis and Rheumatism Associates

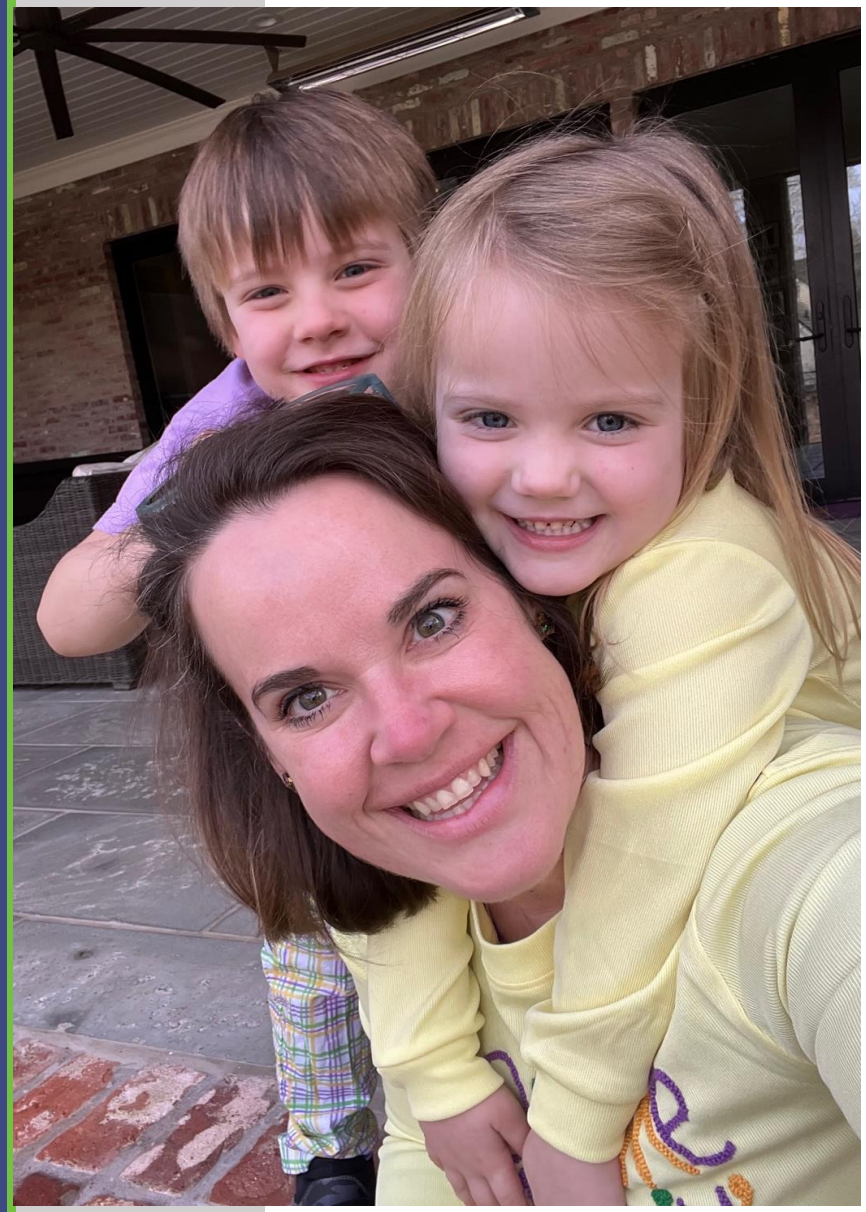
Disclosures

I accept money from the following:

Blue Cross Blue Shield, United Healthcare (occasionally), Cigna, Aetna, Humana, Medicare

I also accept money from:

Janssen, Abbvie, Amgen, UCB, Mallinckrodt, Horizon, Chemocentryx, Genentech, GSK, BMS, Radius, AstraZeneca, Eli Lilly, Sandoz, Aurinia...



Aaron Broadwell, MD

- Private practice, Shreveport LA
- 5 physician, 5 APP practice
- Infusion, MSK U/S, x-ray, DEXA, minimal research
- Practice started in 1990's
- Vice President & Secretary, CSRO, Chair- Payer Issue Response Team
- Past-President RAL, Payer Relations Chair
- Rheumatology Curriculum Chair, Willis Knighton IM Residency
- Gratis Faculty, Rheumatology Course Director, LSUHSC FM Residency

Choosing your Niche

- Academic Medicine
- Hospital Employment
- Private Practice Employment
- Private Practice Ownership
- Military/VA
- Pharma
- Insurance Company

Pharma Employment

- Medical Directorship
- Involvement in clinical trial development, process
- Often requires relocation to headquarters (less than before)
- Medium salary, lower high end
- Can start directly out of fellowship or with little experience
- Highly corporate structure

Insurance Company Employment

- Who hasn't dreamed of being the other person on the phone denying patient the care they desperately need?
- Certainly, there are useful jobs here...

Military/VA

- Variable salaries, lower high end
- Limited treatment options
- Antiquated systems (VA)
- No control over staff (usually understaffed)
- Generally lower workload
- Great benefits

Academic Medicine

- Relative job security?
  - APP replacements
  - Large institutions are feeling the same “pinch”
- Possibly higher starting salary
- Generally lower high-end salary
- Teaching
- Publishing requirement
- Lack of credit for ancillary services (huge profit center)
- Less autonomy
  - Number/type of patient assigned
  - Office staff

Hospital Employment

- Better starting salary, lower high end
- RVU targets, adjustments
- Risk of facility fees removal (-->lower salary)
- Hospitals often claim to lose money on clinic physicians
- Extensive support staff (that you don't worry about)
  - But that you don't control
- Likely no ancillary income

Private Practice Employment/Ownership

- Large multispecialty
- Large (6+) single specialty
- Small (2-5) single specialty
- Small multispecialty
- Solo

Large Multispecialty

- Larger groups (with PCP base)
  - Cost sharing/profit sharing
    - Imagine the neurology department losing money on IVIG affecting your bottom line
  - Can truly profit from your overall work depending on design
  - You are stuck with whatever patient type PCP's need (FMS, OA)
- Specialists only
  - Often use profit sharing/cost sharing models, economies of scale
  - Devil is in the details about how these are shared

Large Single Specialty

- Often state or region-specific
- Economies of scale maximized and not spread between specialties
- Admin burden can be high
- Common goal
- Easier to leverage all ancillaries (including research)
- Risk of sale

Small Single Specialty

- Single (or at least narrowed) focus
- Lower economies of scale
- Limited sharing overhead
- Lower starting salaries, highest ending salaries
- Higher risk, possibly higher reward with low overhead
- Risk of sale

On your own?

- Solo Private Practice
  - Highest risk, highest reward
  - 24/7/365 responsibilities
  - Solely dependent on you to operate
    - Find help for coverage for vacations, leave, etc
  - You eat what you kill (minus what you cost of course)
    - No Stark enforcement
  - May take 1-2 years to become profitable?
  - No economies of scale
  - Limited negotiating power (but who really has much?)
  - Opportunity to use a concierge or DSC model

On your own..

- It can still be done!
- Know your location, demand, regional healthcare economy

So, you chose solo/private…

- Where?
  - Rural/smaller cities
    - Lower cost of living, lower fee schedules than some areas
    - Often higher demand (longer wait lists, can choose who you want to see)
  - Urban/Large metro areas
    - Higher cost of living
    - Sometimes lower demand
  - Fee schedules vary per region (ie NY, FL, CA private fee schedules are lower than South/Midwest)
  - Location near family/support?

What might you need to know?

- Billing/coding
- Revenue cycles
- EMR choice
- MIPS/MACRA
- Insurance
- HIPPA compliance
- Drug purchasing
- Staffing
  - Health/business insurance
  - Pay
  - OSHA
  - Retirement plan
- Stark
- Sunshine Laws
- ACO's, bundled payments, MVP's
- Oh yeah and be a doctor!!!

But how can you know?

- Join your state society
- Join/follow CSRO
- Join NORM (National Organization of Rheumatology Managers)
- Join relevant social media groups
  - Rheumatology Private Practice Group
  - Private Practice Physicians
  - Direct Specialty Care

But isn't private practice dead?

- Data shows that >70% of rheumatologists are employed.
- It does get harder each few years to maintain a private practice
  - Hospitals too!
- There is a movement back toward private practice
  - Leverage that you are both the
    - Lowest cost center
    - Most personalized experience

Will you be busy enough?

- Your worst nightmare in a new practice is a day seeing no patients
  - Quite a difference from fellowship!
- Rheumatologists are in high demand
- High variability by city, state, region
- Can ask colleagues about wait times
  - Call offices if they won't tell you
- In most situations, you will be plenty busy... :)

How to build a practice

- Get to know folks!
- Provide a brand/service that referring physicians need
- Make it patient-centered
- State licensure
- Hospital privileges (or hospitalist agreement)
- Insurance credentialing (can take forever)
- Hire a team you can trust

What about AARA (Bendcare), United Rheum (Specialty Networks) and others?

- Several opportunities exist for help in private practice
- Supergroups (AARA, Articularis, etc.)
  - Combined TIN
  - Can help negotiate insurance contracts
  - Benefits packages, billing, staffing expertise
  - Mandated EMR (leverage data)
- United Rheumatology, ARN, others
  - GPO offering
  - Can be more "cafeteria style"

One sad truth..

- Cognitive care (E/M codes) is not reimbursed well
  - Complex patients are the rule in rheumatology
  - Ancillary revenue can help offset higher costs of business

To infuse or not to infuse?

- Excellent/needed service
- Much less expensive in PP vs hospital outpatient
- Very high risk/high reward
- How to start:
  - AARA/Supergroup
  - Infusion management company
  - On your own (highest risk, need knowledgeable billing staff)
- Join a GPO (this is free!)
- Complex admin coding
  - Thanks, CSRO!
- Know your Prescribing Information (especially for Medicare)

In office dispensing

- Similar to (but importantly different than) infusions
  - Patients need the drugs, you can be part of the process
  - Very convenient for patients to be able to fill at their physician's office
  - Significant barriers to entry
    - State laws
    - Ability to participate in networks
    - Volume/mix of Rx's
    - Risk of loss to audits, DIR fees and claw backs (what pharmacists have dealt with for a while)
    - Significantly rebated drugs are difficult to make profitable
      - Current prospects include lesser used drugs (Simponi SQ, ?Xeljanz)
  - Several players in the market (HouseRx, United, McKesson, etc)

Imaging

- Xray, Ultrasound, MRI, DEXA/TBS
  - Integral to care
  - Check with local regulations
  - Consider learning how to read U/S (USSONAR vs others)
    - Best to read in house (reimbursement changes)
  - Learn x-ray in fellowship
  - Optimally, you should review
    - Unreliable hospital reads
    - PACS access if you don't have it in house

Laboratory Services

- CLIA certification
- Stark regulations
- Specialty labs (Theratest, others)
  - Run autoantibody testing, other specialty labs
  - Can return higher margins, but at times due to higher utilization
- Basic lab services
  - Much lower margins
  - Fast results, ability to STAT labs in house

Research

- Pharma funded research
  - Access to non-approved drugs
  - Access for patients who can't afford treatments
  - Financially advantageous for clinic
  - Helps personal knowledge/growth

Pharma consulting/promotion

- Disclosure: I speak and/or consult for almost every rheumatology pharma company that exists
- Pros:
  - Learn minute details of drugs
  - Better data access
  - Consulting in trial development
  - Publications
- Cons:
  - Sunshine Act
  - Can’t perform as a government employee in many cases
  - Bias, or perception thereof

Advanced Practice Providers (NP's/PA's)

- Can be valuable members of the clinical team
  - Increase your "reach"
- Training should be extensive
- Pick your model
  - Beware FMS/OA burnout
  - Beware unsupervised care
- Incident-to guidelines.
- Beware "signing on" to supervise APP's without seeing patients!

Insurance

- Learn how it works
  - Saves time for you and patient
  - Work against it or work with it
- Must decide what insurers you will accept and will not
  - Medicaid? (rates)
  - Medicare advantage plans? (affordability)
  - Healthcare exchange plans?
  - DSC and/or concierge practices

Running a Private Practice

- Balance of physician and entrepreneur
- Forward thinking (constant game of whack-a-mole)
- Diversification
- Center on the patient care experience

What do YOU want?

- Considerations:
  - Work/life balance
  - Risk tolerance
  - What does your desired location tolerate?
  - Entrepreneurial desires

Remember..

- **You are in demand**
- You can run a private practice on your own if desired
- If joining a large group or academic center, scrutinize the contract!
- Corporate medicine is not as stable as it seems
- There are good people out there...

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Questions?

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