Executive Resources, LLC

January 2007

Executive Resources, LLC ("EXEC")

Health Care Issues Winter 2007

Demonstrating Community Need - Physician Recruitment

- Traditional physician needs assessment is ratio or visit driven
- Physician needs assessment is key for OIG, IRS, Stark documentation
- Many recognized visit ratio sources are outdated or do not have subspecialty ratios
- Physician needs assessment is the cornerstone of medical staff development
- Need to look at changing demographics—both the service area and of physicians
- Physician needs assessment should be updated on an ongoing basis

Inside this issue:

COMMUNITY NEED—PHYSICIAN RECRUITMENT

Executive Resources, LLC (EXEC), with offices in New Jersey, Florida, and Louisiana, is nationally recognized as health care experts relative to ambulatory care and physician development, along with strategic and business planning. Strategic planning includes a needs assessment component, which is integral to program and service development and equally so, to medical staff development and physician recruitment.

Physician Needs Assessment is recommended for physician recruitment (primary care, subspecialty care, surgery) for OIG, Stark, IRS, and anti-kickback purposes. Demonstrating physician need is in many cases, "ratio-driven" predicated on physician-to-population or patient visit ratios, some outdated, some current ratios utilized – such as Graduate Medical Education National Advisory Council-GMENAC, Medical Economics, and Hicks & Glenn among others.

The objective of our ***Physician Needs Assessment*** projects for health care recruiting entities (i.e. hospitals, health systems) as to OIG, Stark, IRS, anti-kickback purposes is to provide objective evidence of the need for the services of the recruited physician in the community for which he/she is to serve along with support documentation.

EXEC takes ratio-driven need to another dimension. For many physician subspecialty and surgery areas, there is limited "other" ***Physician Needs Assessment*** information available. The traditional ratio-driven methodology of demonstrating physician need, which is the cornerstone of medical staff development, must be modified or discarded in favor of other community need documentation that will provide the necessary objective evidence as the rationale for recruiting the physician. Besides physician-to-population or patient visit ratios, we look at changing service area demographics, physician demographics , and health indicators.

For example, recruiting a Colon & Rectal Surgeon (no physician-to-population ratios), requires a different approach to demonstrating community need such as:

- Determine community population service area (town & zip).

- Determine current and future (3-5 years out) service area population (total, age-specific)

.(Continued on page 2)

1/19/2007 New York Times: Groups Offer Health Plan for Coverage of Uninsured

A coalition of business and consumer groups, doctors, hospitals and drug companies laid out a major proposal on Jan. 18 to provide health coverage to the nation's uninsured by expanding federal benefit programs and offering new tax credits. "It's a careful balance of public and private solutions" said Dr. Reed V. Tuckson of UnitedHealth Group. The 16-member Health Coverage Coalition for the Uninsured, urged Congress to put more money into the CHIP and create tax breaks for the purchase of private insurance covering children. The proposal would cost $45 billion in the first five years. The coalition said Congress should provide tax credits to families with incomes <100-300% of poverty, to buy coverage for children.

The coalition offered longer-term recommendations, saying that states should have the option to expand Medicaid to cover all adults with incomes <poverty.

Latest on Gainsharing: OIG Advisory Opinion No. 06-22

Gainsharing—Alignment of Incentives for Cost Savings Strategies

On November 9, 2006, the OIG issued Advisory Opinion No. 06-22 concerning a proposed arrangement in which a hospital will share with a group of cardiac surgeons a percentage of the hospital's cost savings arising from the surgeons' implementation of a number of cost reduction measures in certain surgical procedures (the "Proposed Arrangement"). The cost savings will be measured based on the surgeons' elimination of waste and use of specific supplies during designated cardiac surgery procedures.

The OIG concluded that the Proposed Arrangement would constitute an improper payment to induce reduction or limitation of services, but that the OIG would not impose sanctions on the requestors of this advisory opinion, in connection with the Proposed Arrangement; and the Proposed Arrangement would potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, but that the OIG would not impose administrative sanctions on the Requestors in connection with the Proposed Arrangement.

The Hospital offers a broad range of inpatient and outpatient hospital services, including cardiac surgery services and participates in the Medicare and Medicaid programs. *The Surgeon Group* is a PA composed exclusively of cardiac surgeons who are licensed in the State and have active medical staff privileges at the Hospital. The cardiac surgeons refer patients to the Hospital for inpatient and outpatient services.

The Hospital has engaged a Program Administrator who will collect data and analyze and manage the Proposed Arrangement and who will be paid by the Hospital a monthly fixed fee certified by the Requestors to be fair market value in an arm's-length transaction for services to be provided. The fee will not be tied in any way to cost savings or the Surgeon Group's compensation under the Proposed Arrangement for which the Hospital will pay the Surgeon Group a share of the first year cost savings directly attributable to specific changes in the Surgeon Group's operating room practices.

The OIG states that arrangements like the Proposed Arrangement are designed to align incentives by offering physicians a portion of a hospital's cost savings in exchange for implementing cost saving strategies. Under the current reimbursement system, the burden of these costs falls on hospitals, not physicians. Payments to physicians based on cost savings may be intended to motivate them to reduce hospital costs associated with procedures performed by physicians at the hospitals. Properly structured, arrangements that share cost savings can serve legitimate business and medical purposes. Specifically, properly structured arrangements may increase efficiency and reduce waste, thereby potentially increasing a hospital's profitability. However, such arrangements can potentially influence physician judgment to the detriment of patient care.

EXEC can assist you in analyzing your potential gainsharing arrangements or develop a program at your hospital with our expert healthcare counsel.

COMMUNITY NEED—PHYSICIAN RECRUITMENT (Cont'd from p. 1)

- Determine components of service area (ie census tract, zip code) that are HPSA for primary medical care.

- Review of available resource material as to population-based and visit-based ratios to use as needed in the project.

- Review (hard copy or electronic format) medical staff directories of service area hospitals along with other sources (MCO directories, yellow pages).

- Compile beginning inventory "raw count" of Colon & Rectal Surgeons – needed to develop raw count in the service area community, not health care provider-specific.

- Telephone questionnaire/survey process of surgeons based on a survey instrument to determine solo/multiple office locations, hours spent in each location, time spent on Colon & Rectal Surgery versus other surgical specialties (FTE determination).

- Telephone questionnaire process to also, where possible, obtain other medical staff development information, i.e. age, sex along with acceptance of Medicaid, wait times for appointments, etc.

- Determine community service area FTE physicians and compare results to national physician information (i.e. AMA) – to-be-determined: ratio, visits, counts, other.

- Determine unmet need/(excess) need in a service area. - Review and analyze, where available, applicable state Department of Health incidence and death rate information (ie cancer incidence rates) along with national information.

- Review & analyze, where available, hospital-related applicable discharge data.

- Review and analyze, where available, hospital-related applicable discharge data for market share purposes, i.e. cases, physician, service area, town/zip.

- Utilize incidence, death, and discharge data information to support need for specialist.

- EXEC's in-house legal counsel opinion and analysis

- Deliverable = narrative document w/support documentation.

Please call EXEC at 800-925-1919 for further details.

Uncompensated Care for Medicaid in Your ER??

Fifteen Philadelphia-area hospi- tals and health systems are suing the federal Department of Health and Human Services to overturn a new rule local medical centers say will force them to provide millions of dollars in uncompensated emergency care to Medicaid patients.

The rule, which went into effect Jan. 1, requires medical centers to accept a state's "default rate" as payment in full for emergency room patients enrolled in a Medicaid managed care plan that doesn't have a contract with the hospital, while the University of Pennsylvania Health System, one of the plaintiffs in the lawsuit, has estimated the new rule could cost the system's three hospitals $10 million a year, reported the *Philadelphia Business Journal (January 15, 2007)*.

In the lawsuit filed at U.S. District Court for the District of Columbia, the hospitals maintained that PA's fee-for-service default rate covers only a fraction of their costs of providing care, and that forcing hospitals to accept the default rate is unlawful because it unfairly benefits privately owned HMOs and gives the HMOs bargaining leverage when negotiating new contracts with hospitals, the *Business Journal* added.

Program and Service Development—Bariatric Surgery

U.S. obesity surgeries for patients age 55-64 soared from 772 to 15,086 from 1998-2004 (2,000% increase) according to a January 11 report by HHS' Agency for Healthcare Research and Quality (AHRQ). The report also found a 726% increase for patients age 18-54. Reasons for the dramatic increases include that obesity surgery mortality outcomes have improved greatly. Bariatric surgery has been proven beneficial in obese persons who have tried and failed to lose excess weight by other means. Doctors may recommend bariatric surgery for patients who have a Body Mass Index of 40+ or 35+ for patients with serious, obesity-related medical conditions. "This report shows that more Americans are turning to obesity surgery and that an increasing number of younger people are undergoing these procedures," said AHRQ Director Carolyn M. Clancy, M.D. "As the rate of obesity continues to climb, the health care system needs to be prepared for continued escalation in the rate of this surgery and its potential complications."

EXEC can assist your organization in baratric surgery program development from concept to implementation, whether commencing a new program or performing a valuation for purposes of acquisition of an existing program.

Thinking About Adding a Subspecialist to Your Practice?

As a primary care practice (medicine, pediatrics, obstetrics/ gynecology) practice administrator – freestanding, MSO, or hospital-based, you may have given thought relative to adding a subspecialist to your practice. Market share penetration, service area expansion, changing demographics, health care indicators – one or all may have a hand in a physician practice developing extended relations with their patients and families. In an area that may be aging, where women having children later in life, an OB/GYN practice may want to offer reproductive endocrinology services. As an extension of an internal or family medicine primary care practice, it may be deemed appropriate to bring onboard a dermatology or endocrinology subspecialist based on the above factors.

One stop shopping in the same and familiar setting facilitates continuity of patient care and referrals from primary care to subspecialty and vice versa without having to travel to different sites. Within the same "group practice," primary care and subspecialty services are integrated and dialogue between both providers is furthered. The ability of the practice to market itself as a full-service group practice and the ability to garner additional revenue streams is heightened with subspecialty service addition as well as the ability to spread overhead costs.

But like with any new subspecialty services within an existing practice, the organization needs to ensure it meets various legal and governmental tests, i.e. Stark, OIG, IRS. If properly structure – operationally, fiscally, and legally - arrangements with bringing subspecialty services onboard can survive the scrutiny from federal agencies. EXEC assists physician and hospital clients alike relative to subspecialty service addition. Call us at 732-974-7200 for further details.

The objective of a Physician Needs Assessment for health care recruiting entities is to provide the need for the qualified physician in the Service Area through contemporaneous evidence.

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America's Health Rankings—How does your state fare?

On December 5, 2006, the United Health Foundation released the 2006 edition of America's Health Rankings: A Call to Action for People and Their Communities. Minnesota remains at the top of the list of healthiest states and has so since 1990. Louisiana is 50th and the least healthy state, while Mississippi is 49th. South Carolina, Tennessee and Arkansas complete the bottom five states. Minnesota is first this year, a position it has held for 11 of the 17 years since the 1990 Edition. While it is still Number 1, the large difference between Minnesota and the average state has declined in the last three years.

Minnesota's strengths include ranking first for a low rate of cardiovascular deaths, a low premature death rate and a low percentage of uninsured population. It is also in the top five states with a low percentage of children in poverty, a low infant mortality rate, a low occupational fatalities rate, a low rate of motor vehicle deaths and a high rate of high school graduation.

Minnesota's biggest challenges are a high prevalence of obesity at 23.7 percent of the population. Louisiana is down from 49th in the 2005 Edition and ranks well for access to adequate prenatal care (82.8%), but ranks in the bottom 5 states on 6 of 18 health care measures.

Scores indicate the percentage a state is above or below the national norm (figure below).

To see how your state fared, call EXEC at 800-925-1919 or read the entire document at www.unitedhealthfoundation.org