BEST PRACTICES

Vol. 13

Cerini & Associates, Certified Public Accountants
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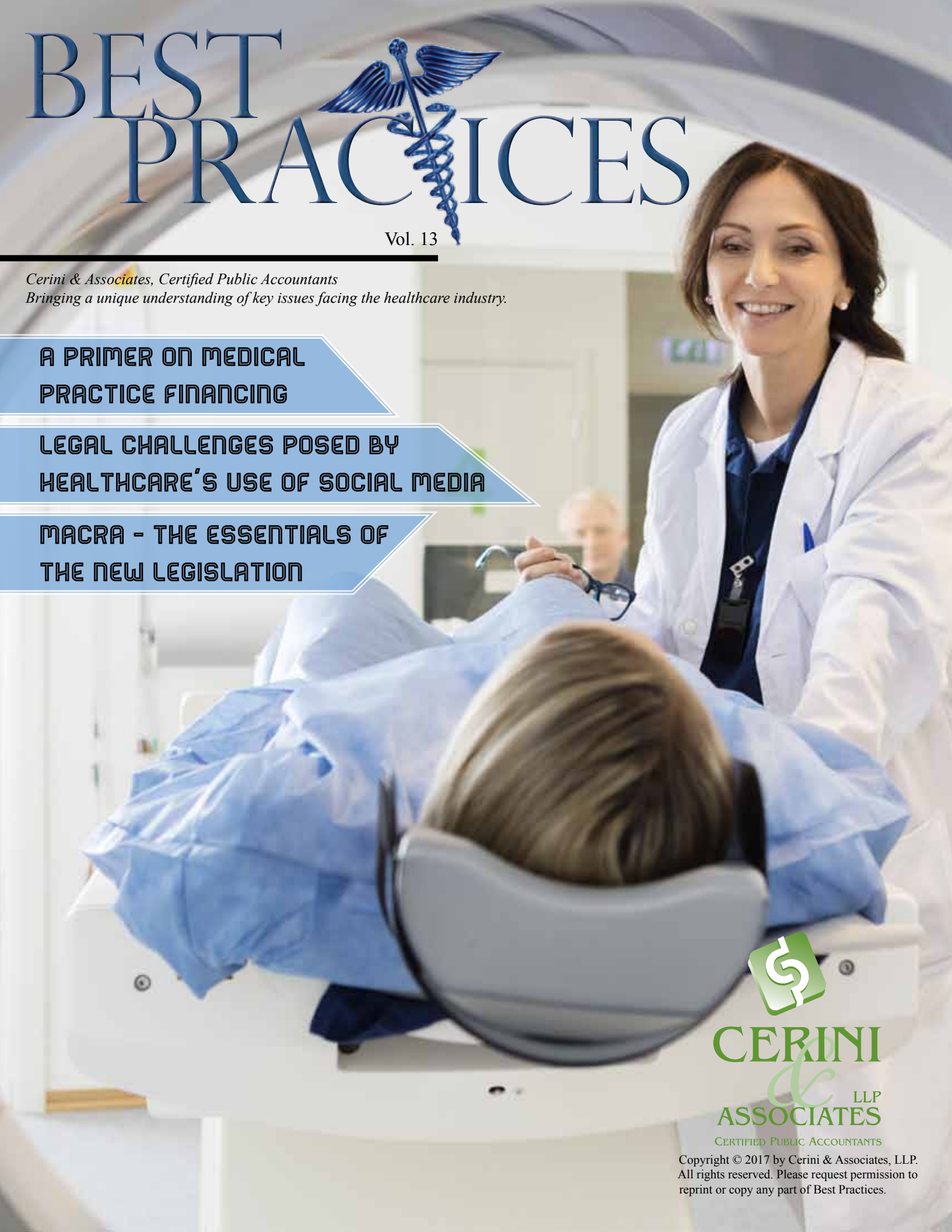

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From the Editor - Tim McHale

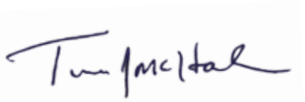
Welcome to the Spring 2017 issue of Best Practices.

This issue features helpful information on acquiring financing for a medical practice, tackling issues with healthcare's use of social media and also include insights on the new Medicare legislation, MACRA.

Reimbursements are shrinking and physicians need to recognize their practice is a business now more than ever. While in the past it was possible for practices to be profitable in spite of themselves, reduced margins are forcing a change in the management philosophy, particularly in the area of finance. Benchmarking your practice in key areas was formally considered a luxury. Previously only available for large practices looking to squeeze every last dollar of profit, it is now a bare necessity for any practice who wants to keep the lights on and patients satisfied.

New legislation and technology will always have a place in the forefront of provider's minds. This can be especially true if these changes will have a material impact on the business of the practice. Changes in reimbursements from Medicare will flow downstream to insurance payers and practices should seek what changes will maximize their reimbursements. Providers should embrace new technology that can both drive patients to their practice and increase clinical care along with the bottom line.

The answers to these questions and more will help move a practice along its growth curve and prevent it from getting left behind. We specialize in understanding and connecting to your practice, growth and overall success. If you would like Cerini & Associates to help create your success story so that you can offer your patients the best care, please call us at 631-582-1600.



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A PRIMER ON MEDICAL PRACTICE FINANCING

Whether you are trying to decide how to facilitate the acquisition of new equipment or the purchase of real estate, or you need additional working capital, at some point a successful medical practice will need to obtain financing. Understanding the process, and when and how to effectively leverage through financing, is a key component in the growth of both the medical practice and its owners.

After identifying a potential need for financing, the practice should begin to perform due diligence on who will be providing the lending. Equipment companies will work directly with financing companies in order to facilitate transactions; for real estate or working capital, often the lender will be a bank (*either directly or facilitation of a small business administration loan*). As part of this diligence process, ensure the lender has an understanding of healthcare financing and is familiar with your practice area; each specialty has different capital and cash flow generation requirements. Working with a knowledgeable lender will not only make the underwriting process easier, but he or she will also be able to help structure the loan to provide maximum benefit to your practice. As is true of any financing transaction, you should always evaluate alternative lenders as part of your standard process. It may be simple to utilize using the financing provided by the equipment company, but there is no guarantee that they are offering you the best terms.

Practices should seek terms that best suit both their short term and long term needs and goals. The key considerations should be the ***rate and term***. Practices should generally look to borrow at the lowest interest rate possible, and by having alternative lending options available, will be in a better position to negotiate a lower rate. When getting financing, the term of the loan should be long enough to allow the practice to free up cash flow that would otherwise be tied into an asset, while also allowing the asset enough time to generate cash flow to pay down the debt. Sometimes, it may be beneficial for a practice to select a slightly higher rate with a more favorable repayment term in order to ease cash flow burdens. That's why rate should not be the only consideration.

Once rate and terms have been established, the practice will go through the underwriting process next. Here, the financing company will request the practice fill out an application, sign regulatory forms, and provide financial information. The financial information will typically be 2 years of tax returns for the practice and interim financial reports for the current period; in some transactions additional information such as receivables, payor mix, or personal tax returns (*if providing a personal guarantee*). The lending company will be looking to see how and if you can repay the obligation with this information. They will be particularly interested in free cash flow and debt service coverage ratio (*DSCR*). Most lenders have a target DSCR of 1.25x, meaning that your net income (*or free cash flow*) should be 1.25 times higher than the annual debt payments. Once the underwriting is complete and approved, the financing documents will be issued and the loan funded.

Knowing when and where to use debt financing should also be a consideration for medical practices. Just because you have a credit line or you are offered financing does not mean you should use it. A key evaluation is understanding the financial impact of the alternatives to financing.

For example, imagine a practice needs a new piece of equipment for $100,000. The practice can either finance the equipment at 5% or use current cash to pay for the equipment outright. In this case, the practice (*and owners*) should look to the future cash needs of the business and what kind of return that cash would generate if not used for this purchase. Assuming that the practice does not need the cash for operations (*in that it will generate enough from its operating cycle*), therefore either allowing for a distribution to the owner or to purchase the asset, the owners should analyze the return they could get on this cash. If the owners can either get a higher return via investment or pay down higher interest debt themselves, it makes perfect sense to finance the equipment. If the cash cannot get a better return outside the practice via investment or debt repayments, then paying for the equipment outright is a viable option.

Understanding financing is crucial to growing a practice and net worth of the physician owners. Many practices are unware of the process and fear the unknown, and also do not effectively plan for future borrowing needs. Leverage is a great tool that can be a high powered way to fuel growth, but if used ineffectively or too frequently, it can be an anchor on the practice.

Edward McWilliams, CPA
Manager

LEGAL CHALLENGES POSED BY HEALTHCARE'S USE OF SOCIAL MEDIA

The delivery of healthcare services has been profoundly impacted by social media. The virtual dialog that is occurring on social media right now presents an opportunity to improve public health. However there are numerous legal risks posed by social media such as privacy concerns, confidentiality of patient information, and the specter of litigation and professional liability. Professional licensure and medical ethics are also challenged by social media. Of paramount concern is the legal relationship of doctor and patient. The intimate relationship gives rise to an absolute privilege of evidence and testimony. A physician cannot be compelled to disclose confidential information about his/her patient. This fundamental tenet may be at risk when private patient information is made public, as on social media. Erosion of the privilege could radically alter the healthcare landscape.

Prior to the ubiquity of the Internet, individuals relied on their physicians as their exclusive source of healthcare information. Parents may have self-supplemented their doctors' advice by reading, for instance, Dr. Benjamin Spock's best-seller *Baby and Child Care* and other texts. But it was not until the advent of Google, WebMD, and Wikipedia that patients became curious consumers of healthcare information. Not all of the information that is available online is reliable, but some of it is accurate. Many individuals use this database of information and misinformation to self-diagnose, self-prescribe and understand their healthcare conditions. Informed and misinformed patients alike have posed diagnostic and treatment challenges for physicians.

The Internet's world of frozen-in-time webpages has been replaced by interactive social media such as Facebook. Social media has created an online environment of virtual reality, which also exists in healthcare. Realtime interaction takes place, especially on the Twitter and Facebook Live platforms. Anonymity and a sense of immediacy lead users to feel more comfortable and willing to discuss and share healthcare information. Virtual public debates rage concerning the efficacy of drugs, breast cancer screenings, vaccinations, and other controversial public health issues. People are using social media to connect with others affected by similar conditions and to share experiences. The volume of anecdotal and observed evidence that is available on social media platforms provides a wealth of information for physicians to evaluate when prescribing pharmaceuticals and designing patient treatment plans. Formerly, practitioners could observe only limited populations, predominantly their own patients. In contrast, today they can virtually observe and hear about the experiences of large populations. This vast virtual world will lead to better analysis and diagnosis if providers take advantage of the opportunity.

To highlight the wide public acceptance of social media as a source of medical information, there were 785,656 posts on Facebook in 2015 relating to arthritis. The enormity of these patient observations and comments provides a useful and underutilized tool for providers, drug manufacturers, and others. These Facebook posts contain valuable feedback about the efficacy of medications, consumers' experiences, and side effects. Due in part to the vastness of data that is available for review, social media aggregates data and makes it readily available to practitioners and the public alike.

The demographics of the people who post online are not always representative of key constituencies. Today the millennial generation is most engaged with providing and relying upon healthcare information found on social media, but this demographic will undoubtedly spread across age and income groups as the social media platform matures. Research is currently being conducted to examine the reliability of cloud-based empirical evidence.

Social media has become an important source of outcomes-based measurement. These measured results may enable providers to deliver more effective treatments. However, the untested nature of Big Data raises questions about the validity of virtual evidence. Its credibility has not been vetted. Some information is purposely planted on social media as fake news, including in the healthcare space. In other instances, social postings are improperly posted to commit industrial sabotage, to harvest data for marketing, and other unsavory purposes. Oftentimes, information found on Twitter and YouTube is inaccurate or controversial. As with the Internet's WebMD and Google search results, incorrect information can pose life-threatening consequences to individuals who pay it heed.

Social media's palette of disinformation can cause injuries and with them, the potential for legal liability. Even more significantly, health information that is not kept private online may give professional liability insurance carriers the opportunity to deny coverage claims.

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MACRA

THE ESSENTIALS OF THE NEW LEGISLATION

The Medicare Access & CHIP Reauthorization Act (MACRA) was introduced in 2015 to replace the Standard Growth Rate in the Medicare Part B Reimbursement Rates.

The precedent for the MACRA program is to incentivize health care providers to adopt the Advanced Payment Model. The standards proscribed by the law are intended to increase the quality of care given to Medicare patients, and to digitalize medical records.

The MACRA program is estimated to cost $210 billon, yet, only a third of the funding has been acquired. Despite the addition to the federal deficit, the bill went into effect January 1, 2017. Health care providers will have until October 2, 2017 to adopt its provisions.

The new legislation provides for two models for payment:

1) MERIT-BASED INCENTIVE PAYMENT PROGRAM (MIPS)

The majority of providers, 96%, will qualify for the MIPS payment model. This model most closely resembles the traditional fee-based model; however, now it has a qualitative component. There are four weighted dimensions that are utilized to assess the inherent value of the service provided:

- *Quality (60%)*
- *Cost (0%)*
- *Improvement Activities (15%)*
- *Advancing Care Information (25%)*

The weighting of each category will be subject to nominal adjustments as the program advances.

After your score is calculated, it will be used to ascertain what your Medicare payment rate will be. In the year 2017, your score could place you at a 4% increase, or 4% decrease in Medicare payments. The aforementioned upper and lower limits will be exposed to increases annually. In 2021 a rate of ± 9% is anticipated.

The **Centers of Medicare & Medicaid Services** (CMS) have sanctioned a pool of $500 million to pay the top performers of the MIPS program additional bonuses of up to 14.5%.

2) ADVANCED PAYMENT MODEL (APM)

In the APM model, the provider is not subject to the stipulations of the MIPS model. Although, CMS estimates that no more than 4% of physicians would qualify for the APM track by 2023, Congress has mandated that 75% of all Medicare revenue must come from APMs.

The APM structure is projected to yield a guaranteed 5% increase in payment growth annually; however this model of payment shoulders a significant amount of risk.

In order to qualify for the APM model you must be receiving Medicare payments from an Affordable Care Organization (ACO). Although the provider has the freedom to select an ACO, it is important to understand that if the provider fails to meet the metrics designated by the ACO, they will not be rewarded with their shared savings on top of their CMS updates.

LOOKING FORWARD:

The MACRA program is inherently unfavorable to small practices. Statistically, their likelihood of qualifying for the APM model is essentially zero. The APM model is targeted towards larger practices that are technologically advanced. Therefore, a small or individual practice is designated to the MIPS model. Interacting with the MIPS model, the provider is exposed to a crippling competitive disadvantage; they are being scored against larger practices. It is a reasonable assumption that a larger practice will have access to superior resources, which subsequently produces greater quality. In essence, a smaller practice could score well according to MIPS, yet be grossly outperformed by larger practices, resulting in a decrease in the Medicare payment rate. The MIPS model is able to award high performers increased rates because it is reallocating those funds away from other providers based upon their assessed value.

Furthermore, considering the structure of the MIPS model it is apparent that the CMS is trying to drive providers towards the APM model. The MIPS system will undermine smaller practices with decreases in rates that will grow in detriment annually, until they inevitably cannot sustain themselves, or are absorbed by another company. As companies that perform better grow, they will eventually qualify for the APM payment model, and thus will be obligated to comply with those stipulations.

The MACRA program will succeed in centralizing the medical practice into ACOs at the expense of smaller providers. Through this centralization, the influence of the CMS on private practices will grow more prominent. The MACRA program is geared towards larger practices, thus encouraging further consolidation within the healthcare marketplace.

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