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Surgeon opts out of managed care, sees steady revenue

At some point, usually in the midst of struggling with third-party payers over meager reimbursement and oppressive bureaucracy, most physicians fantasize about chucking it all and just dealing directly with patients on a cash basis. It's only a dream for most doctors, but one surgeon in Las Vegas has found a way to make it work.

Opting out is no panacea, however. Consider the potential downsides if you want to seriously think about following that dream.

Five years ago, Las Vegas general surgeon **Kevin Petersen, MD,** founded a practice called No Insurance Surgery to offer surgeries to the uninsured and underinsured for a heavily discounted, all-inclusive, one-time fee. Petersen, who was board certified in 1986 and has performed more than 15,000 surgeries throughout his 25-year career, has opted out of the managed care system and no longer accepts new patients with insurance. He recently performed his 900th insurance-free surgery.

Petersen says his decision to opt out of the system by dropping all contracts with insurance companies is a direct reflection of the troubled state of the healthcare and insurance industries and the growing number of patients without insurance or with too little insurance.

"I simply stopped renewing contracts and they all expired over a period of one to two years," he says. "During that time I did not accept new patients with insurance. I kept all my established patients with insurance, but through attrition and the contracts expiring, now nearly 100% of my practice is cash pay."

> **"I make as much or more than I made when I was the busiest with insured patients but I'm working half as much."**
>
> *—Kevin Petersen, MD*

For the few patients who remain from his previous insurance participation days, he sometimes bills the payer for his services but often just treats those patients for free. The $20 or so he will receive for the office visit isn't worth the paperwork hassle, he says.

Petersen says the move has dramatically changed his practice.

"I make as much or more than I made when I was the busiest with insured patients but I'm working half as much," he says.

Less paperwork, better patient care

Decreasing the bureaucratic nightmare was a large part of Petersen's motivation. According to a recent report from the Health Economics Institute, physicians' offices spend between $23 and $32 billion per year in administrative overhead trying to get paid by insurance companies.

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"The success of No Insurance Surgery has proven itself a sustainable business model and a significantly more patient-centric model of healthcare delivery," says Petersen, who earns roughly the same fee performing surgery without insurance as he does when he performs an insurance-covered surgery. "The cash-only approach to medicine has given me the freedom to get back to why I originally became a physician, and no one outside of the profession tells me how I much time I should be spending with a patient or how I should be treating them. The benefits to patients are obvious. By cutting out the insurance company, there is no middleman, and as a result, I enjoy a stronger and more direct relationship with my patients."

By practicing medicine on a cash-only basis, Petersen is also able to significantly reduce his overhead by eliminating staff previously dedicated to filing insurance claims and paperwork. At the height of his insurance practice, 80% of his staff's time was devoted to dealing with insurance companies, Petersen says.

The cost of a no-insurance surgery performed by Petersen and surgeons affiliated with the practice is 50%–70% less than fees quoted by other physicians who provide insurance-funded surgeries, he says. No Insurance Surgery patients are offered a discounted, all-inclusive, one-price surgery package that includes pre- and postoperative care, laboratory testing, operating room fees, the surgical procedure, and anesthesia/anesthesiologist care. The initial consultation is free.

Out-of-state patients are initially screened through an extensive online survey, then a detailed telephone consultation with Petersen, before arriving at his office in Las Vegas for an additional pre-surgery consultation.

Petersen and his staff pre-negotiate all fees with medical facilities, anesthesiologists, and all other healthcare providers involved in a given surgery.

"We know what these services really cost, and given the volume of our practice, we are able to negotiate excellent prices for our patients that are far less than what they are charged for identical services covered by insurance," he says.

Consider the downsides

Uninsured patients from Las Vegas and across the United States, as well as many Canadians unwilling to wait for treatment in their home country, are seeking Petersen's surgical services. The largest demographic of Petersen's patients are early retirees in their 50s who are too young for Medicare and young adults in their 20s who are uninsured, either because their jobs don't provide insurance or they can't afford or don't qualify for coverage. Patients include young men who need hernia repair before entering the military, athletes, young people whose part-time jobs don't provide benefits, and the self-employed for whom insurance is too costly.

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If this strategy works so well, why don't all physicians employ it? Petersen says there are some good reasons. First, insurance practice does not mix well with cash practice, which means that going only halfway isn't really feasible, he says. The physician has to commit to completely converting to cash only, which can be a big change for most practices. When you try to mix the two, the insurance part of the practice takes too much of the staff's time and they end up resenting those patients, Petersen says.

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More physicians dropping third-party payers

When it appeared that Medicare reimbursement rates for physicians were to be cut 21% in 2010, 84% of physicians in a poll said they would have to stop seeing new Medicare patients, stop seeing all Medicare patients, or consider closing their practices altogether. The continued uncertainty about the future of healthcare is causing many physicians to keep those options on the table, says **Daniel Palestrant, MD,** CEO and founder of Sermo, the nation's largest online physician community *(www.sermo.com)*.

Many practices, private and group, had planned to opt out of Medicare as of March 1, 2010, but then Congress stopped the planned rate cut. Many physicians explained on Sermo how they simply could not make up for the declining payments by increasing volume of patients seen. For some practices, the bulk of the physician's patients are on Medicare and Medicaid. One doctor of osteopathy said, "Medicare makes up about 50% of my practice. I cannot afford to stop seeing them altogether right now. Either way I will have to significantly change my practice to reduce overhead to survive the cut."

Although the cut was halted, physicians are not resting easy, Palestrant says, largely because more rate cuts are possible. According to the most recent Congressional Budget Office estimate, if nothing is done, physicians will see reimbursement for services provided to Medicare patients drop by 29.4% on January 1, 2012. In addition, the upheaval in healthcare has left doctors more uncertain than ever about how to cope with managed care and third-party payers. Physicians are particularly disillusioned by what they believe is Congress' attempt to control the practice of medicine, Palestrant says. One surgeon wrote on Sermo that "the government cannot be allowed to legislate that we take on unprofitable endeavors. It is time for all physicians to take a stand for a fare wage." A dermatologist added, "Medicare needs to get out of the price-fixing business."

An earlier survey by Sermo indicated that physicians are moving toward cash-only practices as they cope with the business realities of an uncertain healthcare environment.

According to a Sermo survey conducted of 1,000 U.S. physicians:

- 61% have accelerated dropping third-party payers given the 21% proposed cut in physician Medicare payments
- 91% of physicians say they could discount their services by up to 40% if they didn't have to pursue reimbursement from third-party payers

Due to the increased burden of administrative overhead and cuts in payments for services, many physicians are weighing the benefits of cash-only practices, Palestrant says. When asked to select what their goals would be for improving patient care if they moved to this model:

- 80% selected "lower influences of third parties on treatment plans"
- 75% selected "more time with patients"
- 75% selected "encourage patients to have a greater vested interest in their own care"
- 60% selected "provide services to patients that have no insurance or high-deductible [health savings accounts]"
- 60% selected "I could offer patients more flexible payment terms and discounts"

"Our data continues to support the fact that physicians are becoming more and more concerned about the business realities now facing them," Palestrant says. "Because of this, we're seeing a powerful trend in the Sermo community where physicians are turning toward new business models that can help improve their financial underpinnings and reestablish the centrality of the doctor-patient relationship."

Not so fast: Opting out isn't that easy

Opting out of Medicare may seem like an attractive strategy, but it requires careful consideration. This path won't be right for everyone, and you have to consider whether your patient base is willing and able to pay on a cash basis.

Even if patients end up paying the same amount and can be reimbursed directly by their insurers, some will balk about having to front the money. The notion of third-party payers taking care of healthcare expenses directly is deeply ingrained in the American mind, some experts caution.

Also, remember that you can choose to opt out of one plan—Medicare, for instance—but still accept others, like private insurers. This does not have to be an all-or-nothing decision, although mixing insurance and cash payment can come with its own complications.

The Association of American Physicians and Surgeons (AAPS) in Tucson, AZ, is an advocate of opting out of Medicare, but still it cautions physicians to consider the ramifications and obligations that come with that decision.

AAPS offers the following advice on opting out:

- **You will have to maintain the opt-out decision.** Physicians must remember to refile the affidavit every two years. Otherwise, the opt-out will be nullified and all of the private contracts during that period deemed null and void. The physician may then have to file Medicare claims for services provided under voided contracts.
- **Opting out may allow you to make certain self-referrals.** Federal rules state (in 66 *FR* 856, 1/4/01) that a "physician who opts out of the Medicare program and is not receiving any payments from the Medicare program is not bound by the limitations in section 1877 ... and, therefore, can refer to entities with which he or she has a financial relationship." But the AAPS cautions that you should check your plans with an attorney before engaging in such referrals.
- **The entire practice does not have to opt out.** Individual physicians can make the decision. "[W]hen a group physician has opted out, it does not affect the ability of the rest of the group members to furnish and bill for services they furnish to Medicare beneficiaries. ... [H]owever, ... when a group physician has opted out, the group may not bill in its own name for services provided by the opt-out physician under a private contract. ..." (66 *FR* 856, 1/4/01)
- **Even after opting out, physicians can still order Medicare-covered services for beneficiaries.** "The physician or practitioner who has not been excluded under sections 1128, 1156, or 1892 of the Social Security Act may order, certify the need for, or refer a beneficiary for Medicare-covered items and services, provided the physician ... is not paid, directly or indirectly, for such services (except as provided in §405.440 [regarding emergency and urgent care services])." (63 *FR* 58903-04, 11/2/98)
- **Opted-out physicians may bill Medicare for emergency services, or they can privately contract with those patients beforehand.** When a patient is in an emergency or urgent care situation, he or she is considered unable to consent to private contracting. Accordingly, an opted-out physician may bill Medicare for services rendered to such a patient. (63 *FR* 58904, 11/2/98)
- **There is a safe harbor for inadvertent failure to maintain opt-out.** There is some flexibility for good-faith failures by opted-out physicians to obtain private contracts. "When a carrier notifies an opt-out physician or practitioner that he or she appears to have failed to maintain opt-out by not entering into a private contract, he or she may continue to opt-out if he or she makes good faith efforts at fixing the problem that led to the failure to maintain opt-out and notifies the carrier of these efforts within 45 days of the carrier notice." (63 FR 58858, 11/2/98)

For more advice from the AAPS, go to *www.aapsonline.org/medicare/optout.htm.* The website has specific advice on how a physician practice can opt out, including samples of the affidavits that must be filed and the steps that must be taken to notify patients. A participating physician must first terminate his or her Medicare Part B participation agreement, which allows termination on a quarterly basis.

Steady revenue

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"Another reason that many doctors won't go to cash only is that they think the liability is higher because the patient may not have the money to pay if their treatment becomes more complicated than you expected," he says. "If you don't do what is needed because they can't pay, then you didn't deliver the standard of care and you're going to be sued."

That fear is overblown, Petersen says. In an emergency, the patient would be hospitalized and the care would be covered; the patient can then be referred to other providers for treatment that will be covered by Medicare or Medicaid.

Petersen notes that the demographics of your practice also are important when considering this strategy. If your patients are mostly employed full time and have plenty of insurance coverage, they may not be attracted to a cash-only practice. That would mean either switching the focus of your practice or risking the loss of much of your patient base, he says.

No regrets, surgeon says

Based on the success of the practice's focus on hernia and gallbladder surgery, Petersen has expanded his practice by recruiting other qualified surgeons to treat patients in need of eye, hand/arm, and spine surgery as well as those with gynecological problems in need of hysterectomies and surgeries to treat uterine fibroids, adenomyosis, and endometriosis.

Since Petersen first began offering No Insurance Surgery in 2006, he has treated patients from every state in the country, Canada, and 13 other countries. The practice has more than 25,000 patients needing care in its database, and the website has logged more than 1 million visits since its creation. Petersen says he will continue to treat existing patients on a fee assignment basis and will treat insured patients out of network.

"I have zero regrets about shifting away from insurance because my relationship is much better with my patients," Petersen says. ■

'Economy of healthcare is broken,' benefit manager says

The healthcare structure in the United States is so dysfunctional that physicians should look for opportunities to reformat their practices for the future, says **Tom Loker,** COO of Ramsell Corporation, a company that manages care and benefits for state and federal programs, based in Oakland, CA. More than ever before, efficiency may be the key to whether your practice provides a decent revenue stream or becomes untenable.

"The economy of healthcare itself is broken," Loker says. "Whether you are a physician, a pharmacist, a hospital, a payer, or a consumer of the services, the entire method we use for deriving payment is broken. It's faulty."

Loker uses routine laparoscopic appendectomy procedures as an example. Eighteen years ago, he says, the hospital invoice would have been about $10,000. The hospital actually would have been reimbursed about $2,500, or 25 cents on the dollar. Two years later, the same procedure cost $12,500 and the hospital was reimbursed $2,500, still 21.5 cents on the dollar.

Today, the same appendectomy can result in an invoice of up to $45,000, and the reimbursement will be about $8,500—just 19 cents on the dollar.

The problem in pricing comes from two categories, Loker says. "On one side you have pricing driven by CMS and Medicare/Medicaid reimbursement rates. So you have prices being driven down by them on a DRG basis, and that results in more and more doctors saying they can't participate at those rates and turning away Medicare and Medicaid patients. On the other side you have the payers continuing to negotiate discounts, from 20 cents on the dollar, to 19 cents, to 18 cents. Lower all the time."

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Healthcare is broken

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As a result, physicians can't tell what they're going to make from year to year because every plan is a little different. The physician can't build a revenue plan around a certain reimbursement strategy because reimbursements are all different and constantly changing, he says.

> **"You have to lower the cost if you are going to have any hope of making this business at least a break-even business, much less make any money while you are servicing government programs."**
>
> *—Tom Loker*

The private payer ends up getting cheated too, Loker says, because they are presented with the total invoice for treatment and usually do not realize that government programs and insurance companies pay only a small fraction of that amount.

"The biggest issue we have in healthcare, before we get into debating the merits of any healthcare reform, is that the entire economic system of the delivery of healthcare does not work," he says.

Physicians are responding by leaving their practices in growing numbers, Loker says. He notes that providing treatment under a government program is becoming much more of a loss leader for physician practices. Government programs continually lower their reimbursement rates in what Loker says is an effort to drive the profit out of healthcare. "The problem is that doctors are driven by a profit motive, and if you're going to really try to squeeze all the profit out, you're getting rid of your delivery system," he says. "These guys are getting to the point that they can't afford to keep their doors open."

Until the entire healthcare system is overhauled, Loker urges physician practices to maximize their efficiency when working with any government program, including Medicare and Medicaid. Government programs require adherence to a complicated set of rules and procedures, and Loker says physician practices tend to fall short in two areas:

1. **Not clearly understanding the documentation steps in the program and the limitations of the program.** Providers can err by not being specific in checking the eligibility of the patient to participate in the program, and also by submitting for reimbursement without using the authorized codes.
2. **Failing to plan for audits.** Most programs can audit the provider for periods seven years prior, and the provider is expected to have the necessary documents to justify the compensation received.

"During an audit, most of the problems come down to the provider not having the proper documentation, rather than what looks like fraud or mistakes in billing," Loker says. "If you have not kept the documentation in such a way that the auditor can tie it back to the billing under question, it's impossible to say that the billing was legitimate."

Loker advises using automated systems as much as possible so the data and transactions are captured automatically, although he says that does not eliminate the need to maintain the original documents.

"The key is making sure you leverage whatever automation you can to manage the revenue systems," Loker says. "You have to lower the cost if you are going to have any hope of making this business at least a break-even business, much less make any money while you are servicing government programs. You just have to build the volume and use that volume to lower the costs and get some economy of scale in the rest of the business." ■

More physicians receiving on-call pay daily or annually

Providers who indicated they received on-call compensation were more likely to be compensated daily or annually, compared with previous years, according to the MGMA's latest *Medical Directorship and On-Call Compensation Survey: 2011 Report Based on 2010 Data.*

Thirty-five percent of providers reported receiving on-call compensation daily (for the days they were on call) and 21% reported receiving an annual payment for on-call coverage in 2010. Invasive cardiologists reported the highest median daily rate of on-call compensation at $1,600 per day on call. General surgeons earned a median of $1,150 per day and urologists earned $520 per day for on-call coverage.

Practice type can affect a physician's on-call compensation. OB/GYN physicians in single-specialty practices received median compensation that was twice that received by their peers in multispecialty practices ($500 versus $250, respectively).

Invasive cardiologists reported a 33% difference in median on-call compensation between single-specialty groups ($1,000 per day) and multispecialty groups ($750 per day).

Practice size also influenced compensation for on-call coverage, says **Jeffrey B. Milburn, MBA, CMPE,** an analyst with the MGMA Health Care Consulting Group. Anesthesiologists made $450 per day in groups with 25 or fewer FTE doctors, compared to $660 per day in groups with 26–75 FTE doctors. General surgeons in medical groups with 25 or fewer FTE doctors earned a median of $1,000 per day, and those in groups with 26–75 FTE physicians earned $1,475 per day.

> **"Physicians realize the value of their time and services and are negotiating compensation for on-call coverage."**
>
> *—Jeffrey B. Milburn, MBA, CMPE*

"Despite the variability of on-call compensation based on location, specialty, group size, and other factors, physicians now are more likely to be compensated for on-call coverage than in the past, and the amount is increasing year to year," Milburn says. "Physicians realize the value of their time and services and are negotiating compensation for on-call coverage."

Holiday and weekend on-call rates also varied by specialty. Almost all reporting physician specialties received higher holiday rates than weekend rates. Radiologists received $700 more for a holiday rate than a weekend rate. Orthopedists earned a median compensation of $1,025 for holidays. OB/GYN physicians reported a median on-call holiday rate of $125. ■

Groups say ACOs too complex, offers little benefit

MGMA in Englewood, CO, says the government's plan for accountable care organizations (ACO) is overly complicated and offers only small benefits while posing substantial risks.

MGMA submitted formal comments recently on the proposed rule for the Medicare Shared Savings Program, which includes the ACO plan. According to the group, the following concerns are prompting medical groups to steer away from signing up to be an ACO:

- The rules and requirements for participation are too complex
- The cost of developing the ACO and its ongoing operational expenses exceed financial benefits
- The regulatory risks have providers worried about antitrust violations

MGMA addressed the regulatory risks of the ACO program and offered additional recommendations in two separate letters to CMS and the OIG, and the Federal Trade Commission and the Department of Justice.

"Based on feedback received from our members, including those who participated in the [Physician Group Practice] demonstrations, as well as similar private sector contractual arrangements, MGMA believes the ACO shared savings model may not be viable as a national Berwick [CMS Administrator Donald Berwick, MD] strategy unless significant program policies are modified when final rules are promulgated," the letter to CMS and OIG states. (The MGMA statements can be found online at *www.mgma.com/WorkArea/DownloadAsset.aspx?id=1366447*.)

Prestigious healthcare providers also are expressing concern. Mayo Clinic in Rochester, MN, says it will not participate in ACOs as they are currently organized, and Cleveland Clinic in Ohio also has expressed serious reservations.

Mayo Clinic says the proposed ACO organization conflicts with the way it runs its Medicare operations, which treat about 400,000 patients per year. Douglas Wood, MD, Mayo's chair of the Division of Health Care Policy and Research, said in comments to CMS that Mayo does not want to significantly change what it believes is an efficient, patient-friendly program. Mayo will not participate in a Medicare ACO "under the circumstances proposed," Wood said in the letter.

Similarly, Cleveland Clinic CEO and President Delos M. Cosgrove, MD, said in a letter to CMS that Cleveland Clinic supports the concept of ACOs but adamantly rejects the proposed rules that are "replete with (1) prescriptive requirements that have little to do with outcomes, and (2) many detailed governance and reporting requirements that create significant administrative burdens."

"Further, we have concluded that the shared savings component (Shared Savings) is structured in such a way that creates real uncertainty about whether applicants will be able to achieve success," the Cleveland Clinic letter said.

The American College of Physicians (ACP) also has raised concerns regarding the requirement that at least 50% of participating primary care participants within an ACO be meaningful users of health information technology by the second year of the contract.

This requirement, along with several others that have been outlined in the proposed rules for ACOs, has been cited by the ACP as a measure that will limit the participation of many physicians and could hurt the development of ACOs moving forward.

"The college supports the importance of Electronic Health Record (EHR) adoption, but believes that this 50% requirement may be too high a goal—particularly for small and intermediate size practice collaborations considering participating within the ACO program," Don Hatton, MD, chair of the ACP's Medical Practice and Quality Committee, said in a letter to CMS. ■