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Cash Is King

Do you want to be the king of your castle?

By Jason Kraus

On June 18th, the United States Senate threw physicians yet another bone: a six month extension on the status quo, and prevented once again the legislated 21% cut in Medicare fees. Podiatric physicians can breathe a sigh of relief and begin submitting claims, which they were forced to hold for almost three weeks to allow for the arm twisting, lobbying, and all-around manipulation that our political process requires to get things done. Try not to get too excited, however, because you will probably be walking on egg shells again just in time for Thanksgiving, as the current extension only provides support for your fees through November 30, 2010.

The November 30th date seems rather suspicious. With the mid-term elections out of the way and a full year to work with, Congress may finally muster the political courage to let the 21% Medicare fee reduction stand. Nobody knows this for sure, but it seems clear that the overall direction for reimbursement is downward, and that great efforts will be made over the next decade to reduce the cost and complexity of healthcare.

While this may be an admirable goal for our country, it may not produce better outcomes for patients or their doctors. Chances are the current incarnation of the healthcare bill will

Continued on page 80

be changed and modified, and hopefully improved. But no matter what your perspective or political persuasion, the one thing that almost every pundit agrees on is that providing healthcare services is going to be even more challenging in the future than it was in the past.

One of the likely short-term outcomes of all the healthcare policy changes is that physicians may get much busier as the goal of reducing the numbers of uninsured Americans is realized. More patients will be covered and presumably will visit their doctors more frequently, especially for routine or preventative care. The rub, however, is that the fees paid to doctors will be reduced. This sounds a lot like working harder and harder in order to maintain current levels of income. Add the administrative complexity of proper billing, HIPAA HighTech compliance and documentation, and you have the perfect formula for physician burn-out.

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We find ourselves in an unstable environment with more questions than answers. The private insurance company response to the Patient Protection and Affordable Care Act is not yet known. What is known is that the ACT forces these companies to cover more people, many of whom had been previously excluded because of pre-existing conditions. It also forces private carriers to eliminate their annual or lifetime caps in reimbursement. Both of these rules will diminish the profits of private insurers. It is therefore likely that these companies too will attempt to make up for this via some combination of reduced fees, decreased benefits, or higher premiums.

Many podiatrists are feeling anxious, and for good reason. You are not in control of your destiny. You are forced to react to an ever-changing complex environment over which you can exert little or no control. This is not new and has been evolving for 25 years. With every contract you signed along the way with a third party for payment for your services, you have given up more and more control over how your practice runs. First it was financial control, whereby you agreed to accept what these third-party companies were willing to pay. Back many years ago, these fees were considered generous by most podiatrists. Practice became much easier when podiatrists didn't need to worry about the discomfort of discussing fees with patients.

Over time, your practice volume became dependent on the insurance company funnel through which your patients flowed. Once you were so dependent on the insurers for patient flow, they began to slowly reduce your fees. Later, you gave up administrative control. Rather than setting up protocols for the processing of all administrative tasks in ways that worked best for you, you were forced to comply with the procedures that were dictated by the insurers. Next was documentation and regulatory compliance; where once the medical documentation revolved around patient care and clear communications, now it revolves around proper billing and coding.

Converting to the Cash Model

A growing number of physicians have decided that they are "mad as hell and are not going to take it anymore." Maybe they are not quite saying it that way, but they are making some very substantive changes in their practices to help reduce the stress and anxiety of managing in these difficult times. Growing numbers of physicians are deciding not to renew contracts with private insurance companies, and with the looming Medicare cuts, many are opting out of Medicare as well. In other words, they are fundamentally changing the business models of their practices. Is this a viable option for everybody? Definitely not! But it might be for some. Converting your practice from a third-party payer model to a cash model is radical in today's healthcare environment, but more and more physicians are moving in that direction.

There is no doubt that moving in the direction of a cash-only practice model will result in a reduction of the number of patient visits to your practice. Although it may seem counter-intuitive, this does not always translate into a reduction of practice income. It is essential to determine the potential impact on both revenue and

Continued on page 82

profit levels in order to properly evaluate the viability of a new model. There are also non-financial reasons that come into play. These may include the amount of time you may be able to spend away from the practice, the amount of time that you can spend with each patient, and the types of relationships that you may want to establish with your patients, to name a few.

These too need to be reflected upon and be weighed when determining the best decisions for your practice. Transitioning to a cash practice is not an all or nothing proposition. Not all insurance companies are the same, nor are all the contracts that you may have signed the same. There may be some contracts that either provide generous fees for your services, or are administratively practice-friendly, or both. These are contracts that you may want to keep or be the last to abrogate.

In order to explore the revenue impact of opting out of the reimbursement world, you must possess a thorough understanding of your existing client base as well as the demographics of your community. Start your assessment with the information that you can readily acquire. Most practice software can provide you with a list of your active patients and cross-reference the list to which insurance coverage they have. Segregate the patients who are covered by the favorable insurance companies from those who are not. Determine the number of your current patients who do not have any insurance. It is safe to assume that your current cash-paying, or out-of-network patients will remain loyal to the practice, and that any contracts that you want to maintain will continue to provide the same patient volume into the future.

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The inferior contracts that you want to eliminate will cause your patient visits to decline. To determine the magnitude of that decline, it may be worthwhile to survey your patients who are covered by that plan. Asking them whether they will want to, or be able to, continue to receive podiatric services on an out-of-network or cash basis (if there are not out-of-network benefits in their contracts) will help you to quantify the number of lost patient visits. Once this number has been determined, you will need to multiply it by the average Per Visit Value (PVV) for those plans.

In other words, you will want to understand the average economic value of each patient encounter for each insurance plan. To determine the PVV you should divide the total

Continued on page 83

revenues collected on behalf of a plan by the total number of patient visits. Once you have identified the PVV and the total number of anticipated lost patient visits for a particular plan, all you have to do is to multiply one by the other and you will have an estimate of how much lost practice revenue will be experienced by dropping a particular plan. Go through this process with each plan that you are currently participating in, so that you can determine the impact on practice revenues.

It is important not to stop there. As mentioned earlier, there is a difference between lost revenue and lost income. If you change nothing in your practice, your income will decline by $1.00 for every $1.00 of lost revenue. If you anticipate patient visits to decline by 30%, you should be very proactive in reducing as many of your costs as possible in anticipation. This would include staff levels, hours of operation, office and lab supplies, and other office overhead.

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By going through this process, you might be able to reduce your overhead percentage. Remember that you are eliminating the low fees/high administrative cost insurance plans from your practice. What will remain is the high fee/low administrative cost companies. Reduced billing expenses, fewer denials, and quicker pre-authorizations should help to lower the cost of administering your practice. A reduction in your patient visits may enable to you to reduce the clinical staff that you need. You may be able to reduce supervisory personnel and other expenses associated with critical mass reduction.

Adding It All Up

How does all of this add up? Let's look at a practice with current collections of $450,000 and an overheard structure of 70%. This results in a net income level of $135,000. If the elimination of several of the lower paying plans caused a $100,000 decrease in collections, but the practice was able to restructure itself to a 60% overheard structure, the net income would be $140,000. Shockingly, you might be able to have 1,000 fewer patient encounters a year but increase your income by $5,000. The key to accomplishing results like this is to make certain that you eliminate unprofitable contracts,

Continued on page 84

and be very proactive in reducing costs in anticipation of lower patient volumes. In the example above, a $105,000 cost-reduction was achieved. This could equal the cost of two staff members and other variable expenses.

Not every community can support practices that wish to opt out. It is important to know as much about the community that you will be drawing from in the future as it is about the patients whom you currently serve. If your community has a dominant employer that insures a high percentage of the residents, opting out may not be a practical solution. The ideal environment for cash practices are either very affluent communities or ones with a high percentage of uninsured residents. More affluent people are more likely to consider staying with a practice if they can be convinced that there is a real benefit to doing so, even at a higher cost. So your skills and relationships with patients will matter most. In areas where there are many uninsured patients, the pool to draw additional cash-paying patients from will be present.

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What about Medicare?

When deciding about Medicare, you have to be realistic. If these patients represent a substantial portion of your patient population, then opting out may just not be feasible. Conversely, if you are practicing in a young community and your Medicare billing represents less than 20% of your total, it may be worth it. Medicare administrative rules are complex and are ever-changing. Compliance failures are treated harshly. Staying up-to-date and compliant adds a real cost to your practice. You should try to identify the number of work hours each month that are spent by your staff jumping through the ever-changing hoops necessary to remain a Medicare provider.

Eliminating both the cost and the revenues associated with these costs may be acceptable to you, once you have a firm understanding of the net change in your personal income. Remember, if you are not already set up for EMR, this will soon be a requirement and yet another cost to the practice. Something else to bear in mind when considering opting out of Medicare is DME dispensing. By opting out of Medicare, you will no longer be able to supply your Medicare patients with any DME item.

Quality of Life

Some of the most compelling reasons to move medical practices to the cash models are often non-financial. Many family practice physicians who have left the third-party payer system indicated that they did so mostly because of their desire to be a more thorough and competent doctor. By lowering practice overhead and setting fees at levels they deemed appropriate for the services they provided, they were able to dramatically increase the amount of time spent with each patient. Being a part of the system forced their patient interactions down under 10 minutes per patients. With fewer patients, they were able to spend more time in each encounter and provide a higher level of care.

Taking the middleman out of the equation is another benefit of cash practices. The re-establishment of a direct relationship between doctors and their patients removes the encumbrances of insurance company policies, provider network constraints, and the misaligned incentives that have infected our healthcare system. These non-financial reasons can often be more important than the financial ones. Physician burnout is an emotional response to the feeling of helplessness that many experience. Gaining control over this and managing the stress that you allow in your life may have a far greater impact on the quality of life than the often elusive financial promises offered by the reimbursement rat race. ■

Mr. Kraus is CEO of Langer Biomechanics Group and has held executive management positions in the healthcare industry for over 25 years. He is co-author of the PM column Files from the SOS.