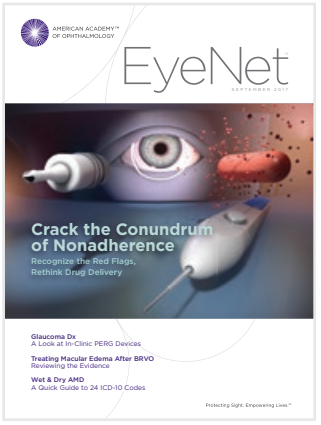
Letters



Medicare Disadvantage

I write in response to Dr. Ruth Williams' editorial "Is Medicare Advantage Driving You Crazy?" (Opinion, September). Requiring Medicare Advantage programs to provide unrestricted access to Eylea, etc., will adversely affect ophthalmology providers unless additional funds are supplied by the Centers for Medicare & Medicaid Services (CMS) to cover these inflated drug costs. With the exception of Avastin, anti-VEGF drugs are priced exorbitantly. When ophthalmologists use them in treatment protocols, medical groups and payers penalize ophthalmologists for excessively consuming the cap allowance for seniors. The Medicare Advantage insurance payers shift the costs of these medications to medical groups. These medical groups suffer financially and stigmatize/penalize the providers for these expensive treatments by cutting payments to the ophthalmology providers.

This situation is untenable without formulary restrictions requiring increased patient copays or additional money from CMS to compensate for the costs of this technology. It is no benefit to ophthalmologists to force Medicare Advantage plans to cover expensive anti-VEGF drugs, as these plans simply shift the financial risk to providers by reducing payments for professional services.

Maria Blase, Administrator
Hemet, Calif.

On Solo Practice

Dr. Williams' editorial on the state of solo practitioners (Opinion, October) garnered many online comments from your colleagues. Below is a small sample, edited and reprinted with their permission.

I have been in solo practice for 45 years and loved every minute. As Frank Sinatra said, "I did it my way." Yes, there is a price to pay in many ways, but there also is a great reward. We are fortunate in ophthalmology, like pathology, to have capable technicians help us with productivity, which makes a "solo" practice really one with many professionals. I am fortunate that my son—who also appreciates the freedom to choose when he may take a vacation or which product he must use—has now taken over the office.

I should note, however, that we have our own ambulatory surgery center (ASC) so we control everything and get both the profit and the headaches when the state shows up unannounced for an inspection. We are the only users of our ASC and run it 1 day a week. We don't make much on it, but it increases efficiency, turnaround time, patient satisfaction and convenience, and our own happiness.

Regarding electronic health records (EHRs): We have decided not to use them and to absorb the penalties for now. We feel that has increased efficiency and provided more happiness.

Frank J. Grady, MD, PhD, FACS
Lake Jackson, Texas

I started my career in ophthalmology in 1981 as a solo ophthalmologist. Over the years, I have had the pleasure of partnering with other ophthalmologists (and, on occasion, optometrists), but I will probably soon end my practice as a solo physician. I have seen a reduction of our local solo physicians in all fields of medicine. In many instances, this decline was forced by the mandatory use of EHRs. These solo physicians were either unable to afford the technology and/or unwilling to devote the time and resources to follow the government mandate. In addition, hospitals and corporate health care systems have been buying out these older solo doctors and their medical practices and replacing them with younger physicians.

In my opinion, solo physicians are like dinosaurs and will suffer the same fate of extinction. I believe that whether we like it or not, our health care system is collapsing from excessive government interference and corporate greed. I have seen virtually no evidence-based medical proof that EHRs have improved health care in the United States. In my view, EHR is really the government's control over physicians and patients, and in the United States we are evolving into a socialized form of government medicine. I am afraid that the future of health care for the American people will be a 2-tiered health care system based on wealth: those patients who can afford private insurance or fee for service, and those patients who must rely on some form of government assistance.

Charles S. Zwerling, MD, FACS
Goldsboro, N.C.

I have experienced 3 different practice models: I was in the Navy for more than 10 years, then in private group practice as an employee for 2 years, then started my own solo practice in 2009. The banks did not offer a good loan arrangement, so my husband and I maxed our 4 credit cards to open the doors, and he worked extra time at his job to pay them off. We got rid of all debt in 6 months, and the practice

started seeing steady revenue in about a year. My worst day at my own clinic (and to be honest there really aren't any bad days) is way better than my best day in the other 2 settings. Solo practices are truly more efficient and cost-effective, but of course it's not in the best interest of big organizations to admit this. You will never regret being your own boss! Having a family-run business gives you more time for your kids and more flexibility. The Merit-Based Incentive Payment System (MIPS) is a clinically irrelevant burden, but I just do the minimum so I don't sweat the penalty. If anyone wants to contact me about starting a practice, I am happy to encourage them—I have no business background, but I learned as I went. If you can go through medical school and residency and pass your boards, you can be a solo ophthalmologist.

Marjorie F. DeBenedictis, MD
Tamuning, Guam

Ho Sun Choi, MD, and I read with great interest Dr. Williams' editorial about the viability of solo practice in this era of health care consolidation. The answer to whether solo practice can survive is most definitely "Yes!"

Dr. Choi, who was mentioned in the article, started his solo practice from scratch, straight out of residency. Although it was an uphill battle, he is doing very well now. He blogged in real time about every step of practice startup. About 20 to 30 young ophthalmologists (including myself) found his blog and used it as a template to start solo practices. This is how the SoloEyeDocs Google group mentioned in the article was founded.

Drawing from our listserv discussions and Dr. Choi's original blog, we are republishing pertinent content as an updated blog: www.solobuildingblogs.com. By sharing our collective knowledge about practice startup and practice management, it is our goal to help all solo practitioners succeed.

As for the challenges to solo practice that Dr. Williams mentions in her article, here are my thoughts:

- EHR costs have been less than 2% of my gross revenues. I will have no trouble achieving a high score on MIPS.
- I found gently used equipment at favorable prices, while my former group practices insisted on paying for everything new without negotiating the price.
- If you are credentialed with the right hospital networks, IPAs, or ACOs, you can often join narrow network plans such as Medicare Advantage or exchange plans.
- Even large health systems have difficulty negotiating contracts with payers. If you can run your practice 20% more efficiently, you will come out way ahead, even with 10% less contracted reimbursement.

Our hope is that more of our colleagues, especially those fresh out of training, will read our blog and decide for themselves that solo practice is viable and perhaps even the best option for their careers. We believe that the field of ophthalmology, as well as the rest of medicine, will be stronger if more doctors are in solo practice.

Howie Chen, MD
Phoenix