The Doctor is In, But She Can't See You

Why I can't pull your splinter and keep my job, and how to fix it

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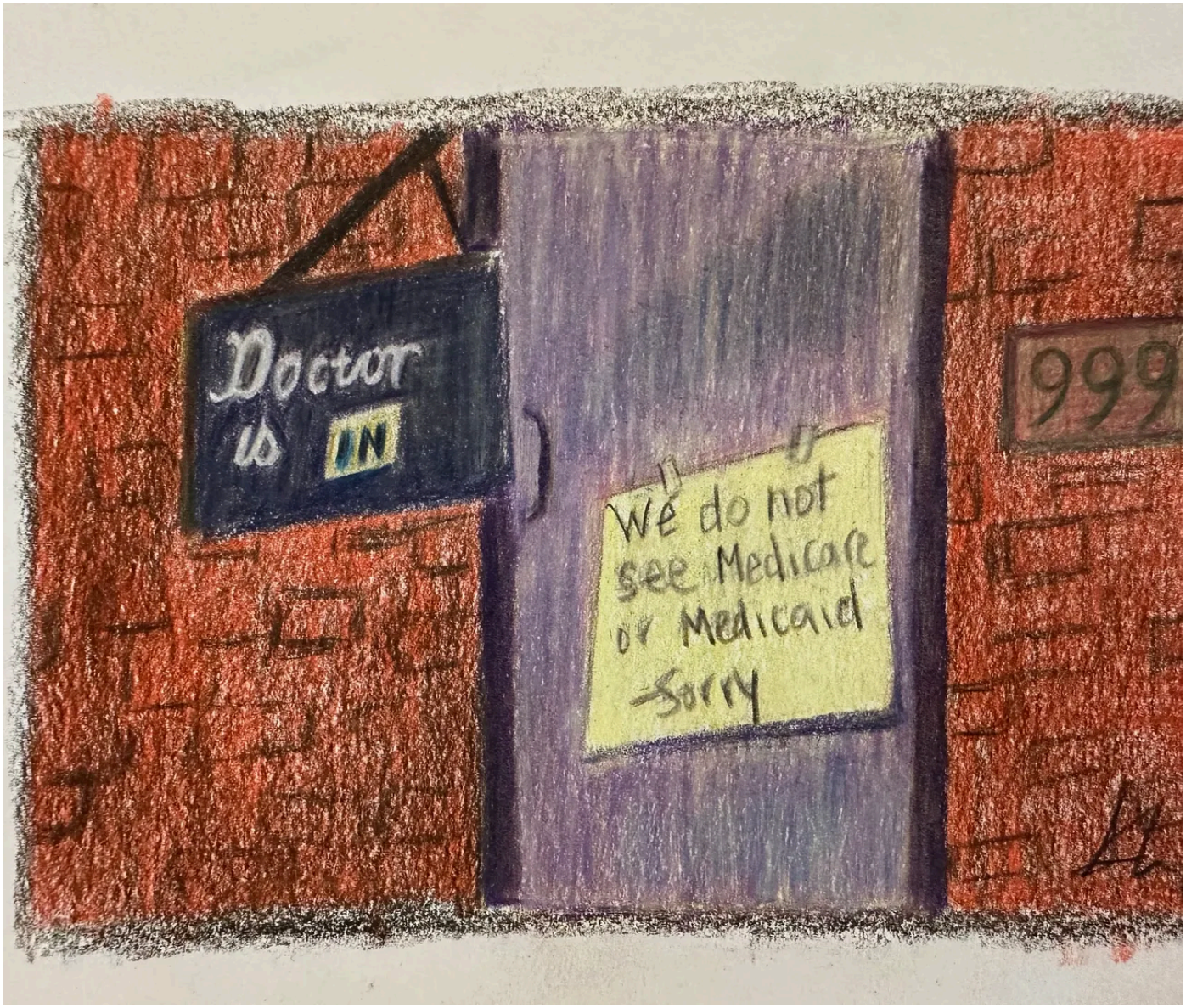

The Doctor Is In. Colored Pencil. By Author.

Lately, I've been fantasizing about being the urgent care doctor for my apartr building in the city. As an emergency medicine doctor, I could stop a noseble finger after it's sustained an avocado-seed-removal-related laceration – all frc comfort of my own ~~home~~ building.

At VertiCare, I could treat your mild asthma exacerbation or begin the treatn before an ambulance arrives if it's bad enough for a hospital visit. I would get all of my neighbors. I could act as a bridge between primary care (to explain n medications) or emergency care (yes, you should call 911 because these sympt could be a stroke). While I wouldn't be able to give blood transfusions, sedati reduce an open fracture, or diagnose appendicitis, as I might in the emergenc department, I *could* treat urinary tract infections, change dressings on wound remove glass splinters from feet. All of this would be done quickly and conve from the comfort of our own home(ish). Plus, my side hustle, Aerie Health, co in a bit of spending money — to get my nails done. As an added benefit, it wc primary care doctors and offload busy emergency departments.

The only way for my Urban Urgent business to succeed would be if I were pa (I also accept checks, PayPal, Zelle, or Venmo.) The beauty of this business is low overhead would allow me to charge below-market rates and the cost of m Billing insurance, Medicare, and Medicaid would add too much overhead. Th paperwork, prior authorizations, and billing intricacies of these various syste require me to hire staff. I'd spend more time doing paperwork than it would t get the eyelash out of your eye and prescribe you an ointment.

But I can't start my cash-pay Sky High Clinic, because if I did, I would have t job in the emergency department. **That's because the federal government, in infinite wisdom, has declared that any doctor who accepts Medicare or Mec *any* patient must accept Medicare and Medicaid for *all* patients, regardless o location or situation**. [2]

Because of this rule, doctors in the US are effectively prohibited from simultaneously in cash-pay practices and traditional practices that accept Medicare and Medicaid. maintain a cash-pay practice as the urban urgent care doctor for my building also working shifts in the emergency department, where I am required to acc Medicare and Medicaid.

If I want to fulfill my dreams of opening RiseHigh Health Care, I must "opt o Medicare and Medicaid, and leave my emergency department job. You're eith you're out.

There are reasons I might be tempted to leave the emergency department. Mu work involves refilling prescriptions and getting X-rays of probably not broke twisted ankles, which is pretty similar to Mile High Health's services. The wo stressful, and the hours are awful — weekends, holidays, nights — circadian r damned.

But the emergency department is also intense, challenging, and exciting. It in catching dangerous diseases, collaborating with talented colleagues, teaching and residents, and saving lives. Recently, I noticed a young patient's heart att the EKG algorithm missed, and my team and I saved the life of a pregnant wo toxic shock syndrome. (The one you get from leaving a tampon in for too long apartment-building-urgent-care business, Suite Relief, would be interesting, t

easy, but it couldn't replace the rollercoaster experience of working in the em department.

Unlike me, some doctors choose to opt out of Medicare and Medicaid, leavin emergency department (or other overworked traditional practices) behind for pastures — urgent care clinics or direct cash-pay gigs. The reason could be a the hardships of working in the emergency department: lack of a predictable loss of family time working nights, holidays, weekends, dealing with the over sense of inadequacy and loss after witnessing death(s), or the never-ending or of patients who aren't satisfied (as evidenced by those Press Ganey surveys). T isn't exhaustive, and it isn't entirely specific to the emergency department. O specialities have their own and similar challenges. However, these are among reasons that emergency medicine doctors retire, on average, 15 to 25 years ea colleagues in other fields.

Emergency medicine doctors aren't the only ones facing this "you're in or opt issue with Medicare and Medicaid. An internal medicine doctor with a specia in infectious disease cannot work as a cash-pay or direct primary care doctor take one week a month of infectious disease consults for a local hospital, whe be required to accept Medicare and Medicaid. A gastroenterologist cannot co with a direct primary care practice to offer a special cash rate for screening colonoscopies and also work in an academic teaching hospital where he must — you guessed it — Medicare and Medicaid.

What does this mean for Skyscraper First Health services?

For one, since I must maintain my enrollment in Medicare and Medicaid, I ca remove the roach from someone's ear and send them a $50 Venmo bill. I have first if they're on Medicare or Medicaid. If they are, I cannot help them; I mu

them away. They will simply have to take themselves and their roach to the h face a three-hour wait with a tickle in their ear.

However, even this might be too great a risk. Because, if a patient lies to me c mistake and forgets their insurance,[3] (because she's been sleepwalking and h head on the refrigerator at 1 am, causing her to forget that the Medicare cove kicked in the day before, on her 65th birthday) I'm still the one held liable anc of being charged with fraud. I could be kicked out of Medicare and Medicaid, fines that are much more than I would ever charge my patients. In extreme ca could even lose my medical license — bye-bye emergency department. The ri attempting cash-pay STATellite Care without opting out of Medicare and Me isn't worth it after all the (eleven) years I put in getting to this point in my car

Alternatively, I could choose to bill Medicare or Medicaid, since I'm enrolled for my regular job. But then I'd have to collect the insurance information, ver coverage, fill out and submit insurance claim forms, wait to be paid for mont probably hire an assistant and therefore raise prices, and likely not even reco cost of materials. (Yes, I need materials — lidocaine to poison the roach first, not using my *fingers* to get it. EEEEW!) This makes my simple cash-pay busin much more complicated and unenjoyable that it's not worth the effort.

Why do these rules and regulations exist at all?

Many of these regulations are attempts to protect patients (especially those w incomes) from exploitation and to protect the government programs from fra agree that being paid by both the patient and Medicare for the same service ('double-dipping') is fraud. However, double-dipping still occurs despite these intended to prevent it. I understand concerns that patients could be taken ad in an emergency, or might not realize they could get a similar service for free

used their insurance. And I wouldn't balk at taking extra steps to be especiall transparent to avoid those scenarios.

But suppose a patient has signed up in advance (not at the moment of urgenc clearly understands the nature of the arrangement. (They can't request reimbu from Medicare and Medicaid, and a list of my charges compared to the usual cost-sharing rate or nothing with Medicaid.) In that case, I don't see this addi option for them (to have the prickly pear cactus needles removed from their a 7am for $50 in their own apartment so they can get to work on time) as proble

First, I'd be making my life better by earning a little money for a service that' convenient for me to provide. Second, I'd be improving my patients' lives by c convenient, timely medical care at a transparent rate. Third, I'd improve the c healthcare situation in the U.S. by enhancing access to care, reducing emerge department visits, and saving the government (through Medicare and Medica expense of those emergency visits.

Currently, no mechanism in the U.S. allows doctors to accept Medicare and M patients in one venue but not in another. [4] The laws for Medicaid in every sta slightly different, making it even more complicated for doctors to know wher doing something that would be considered fraudulent. So many, like me, let c dreams fall away. No little local urban practice on the side, no walking the ha my doctor bag whistling Twisted Nerve, no refilling blood pressure medicatic helping you change the dressing on your chronic leg ulcer for me.

In many other countries, doctors can work in both public and private healthc systems. Singapore and the United Kingdom are two countries that make it v I struggle to understand why some version of allowing doctors to have separa parallel cash pay and traditional practices isn't possible in the US.

Imagine if I could do things my way? It could expand access and choices for p encourage healthcare innovation, reduce costs, and alleviate the burden on ou overworked emergency departments and primary care clinics.

Why not make explicit changes to the federal law?

The law could be amended to allow providers' enrollment and billing in Medi Medicaid to be linked to specific patients (similar to the United Kingdom) or business licenses (similar to Singapore).

In the United Kingdom, this is accomplished through "A Code of Conduct fo Practice," which stipulates, by its very existence, that physicians may maintai public and private relationships with patients. It defines the ethical and legal responsibilities of physicians when organizing these relationships within the practice in the government-funded National Health Service.

In Singapore, physicians are allowed to practice in private and public systems two mechanisms. A Family Practice Plan that is similar to the United Kingdo system, wherein doctors working primarily in publicly funded centers may br portion of private patients. And separately through licensing mechanisms. [6] I works for a public hospital, they would have a license (or employee exemptior depending on their role) for that work. For their separate telemedicine practi physician would require a different entity-specific license. The doctor's paym structure at the hospital is linked to the facility's license. The telemedicine pr payment structure is similarly connected to its license.

Given the mixed system in the U.S. with disparate payment models, the easie correct our system would be to model it after the mixed Singaporean system.

would mean that we link enrollment in Medicare and Medicaid to registered sites and/or healthcare entities. This wouldn't be a giant leap. I currently wor different hospital systems, and both list their addresses on separate Medicare Medicaid enrollment listings for me.

We would implement this by amending the Social Security Act (SSA) and the Federal Regulations (CFR) through bills passed in Congress.

The regulations, as they're written, are long, somewhat convoluted, and are s interpreted differently depending on the state or legal body. So I won't go int detail, but feel free to follow my links if you'd like to read more.

First, a paragraph should be added to SSA §1802(b) (42 U.S.C. 1395a(b)), which defines the rights of a patient to contract with physicians. The new paragrap specify the right of a private practice site or entity to opt out of Medicare, jus subparagraph (3) does for an individual physician. Text would be similar to subparagraph 3, and along the lines of: "(A) In general; Paragraph (1) shall no any contract entered into by a physician or practitioner **at the physician's reg private practice site or at a non-facility private setting linked to a private pr entity** unless an affidavit described in subparagraph (B) is in effect during the any item or service is to be provided pursuant to the contract."

The link to a business or entity would enable mobile practice settings, such a Skyline Health, outside of facilities that provide healthcare through Medicare Medicaid. Otherwise, the same language regarding filing affidavits, consent, of opt-out, enforcement, transparency, and coercion currently in subparagrap could apply or be repeated in this paragraph. [7]

In this case, providers could still opt out of Medicare and Medicaid, but they have to if they were working with an entity that has opted out of these progra

would simply add a site or entity-based private path for cash- or direct-pay pr exist. Doctors can belong to these organizations in parallel. For example, whe working under Elevated Health, the cash-pay entity would be registered as a participating practice and would not bill Medicare or Medicaid. However, thi not affect my enrollment in Medicare and Medicaid associated with my emer department.

Second, a section should be added to 42 CFR Part 405, Subpart D on "**site-bas entity-based private contracting**" that would refer to our initial paragraph ar general rules, regulations, and expectations. This would be the place to inclu guardrails based on international ethical codes of conduct, such as refraining advertising for a private entity while working in a public one, protections fro coercion, providing transparent and informed consent, and ensuring continu care. The United Kingdom and Singapore practices of informing patients abc costs they would incur if they instead used their government-sponsored servi participating entity should also be applied.

Opening these pathways would spark small, low-overhead innovations (such Care Clinic, neighborhood house calls, nutrition services, fast-vax clinics, mo hydration vans, and others that I cannot begin to imagine). These innovations provide patients with real choices and quicker access at competitive prices. T create a bridge back to the traditional system, where physicians in direct-pay can continue to teach, consult, and cover limited hospital shifts, thereby supp the current workforce shortages. The result is a lighter primary-care burden understaffed clinics, fewer avoidable emergency department visits, and a broa pipeline of clinicians. A few explicit statutory changes could have an untold i freedom, choice, and access in America's healthcare system.

What do you think of this plan? Are you a doctor, or do you know any doctors could benefit from legislation that allows doctors to practice simultaneously parallel cash-pay and traditional entities?

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1 I would have an excuse to buy the portable ultrasound probe that works with my p no one will get me for my birthday!) and the mini EKG machine (for the gastritis c chest pain — although in the case of a heart attack, you'd also have a leg up becau your treatment and get to the hospital without delay, EKG in hand).

2 SSA §1848(g)(4)(A) and 42 U.S.C. §1395a(b) and 42 CFR Part 405, Subpart D (see opt requirements and emergency contract sections)

3 You may be surprised to learn that a patient could not be aware they have Medica Medicaid coverage. However, many states with Medicaid expansion use private co (such as Aetna and Fidelis) to manage those plans, and patients often don't realize as Medicaid. Additionally, elderly patients with low incomes, referred to as "Quali Medicare Beneficiaries (QMB)," have Medicare with a Medicaid-like state coverag secondary insurance that helps cover their cost-sharing. Often, these patients are of this. Many mistakenly think that everything switched to Medicare only when th 65. Doctors who have opted out of Medicare and Medicaid can legally contract wi Medicare-only patients, but NOT with QMB patients, and in many states, not wit Medicaid patients.

4 Technically, there is a carve-out for this in federal systems (VA, military hospitals) event of an emergency. However, no hospital will hire an opt-out doctor to work i emergency department, except in the most dire circumstances — it's too complex.

5 As does Germany (but I can't read the German PDF to verify ChatGPT's claims), C
Australia, UAE.

6 Here is an overview. Scroll down to the section titled "Who needs to hold an HSC
for a description showing that doctors working as employees for a publicly funded
exempt, and the entity may still bill for their service. Here is the actual HSCA cod
includes patient protections, regulations, and requirements. Singapore also has a
on Medical Ethics that summarizes many of these guidelines in plain language.

7 Stark Laws would not apply to the new private entity that does not accept Medica
Medicaid.
The Antikickback Statute would still apply, as it currently does for doctors who ha
out of Medicare and Medicaid. These acts are intended to prevent financial induc
referrals. Doctors would have to be careful not to refer patients specifically to the
which they accept Medicare and Medicaid.
The Sunshine Act, which requires the disclosure of financial conflicts of interest,
apply.