IT’S TIME FOR MACRA

Is your practice ready for the new Medicare payment systems coming in January 2017? Now is the time to develop a plan.

PLUS: FULL RESULTS OF THE 2016 PHYSICIAN COMPENSATION SURVEY

also:

INCOME TRENDS FAVORING PRIMARY CARE
KEEP OVERHEAD DOWN; YOUR PROFITABILITY DEPENDS ON IT
Prices for consumer goods are always on the rise and when they go down it is newsworthy (such as the price of gasoline over the past few years). We all have to manage our personal budgets and make adjustments to account for fluctuating prices on essential goods. This is generally referred to as the “cost of living.”

Medical practices are no different. Successfully managing overhead cost can be the difference between being profitable or carrying a deficit. There are three very important areas of overhead cost that should be carefully managed: personnel cost, supplies, and purchased services.

**PERSONNEL**
The biggest chunk of overhead is almost always personnel cost. Most businesses will give employees a cost-of-living raise every year, usually recommended to be in the 3-5 percent range. However, if you have an exceptionally lean year, this can be lower than the average.

The first question a medical practice should address is whether you need as many employees as you have on the payroll. It is worthwhile to critically analyze how many people you have in each position and if you can get by with less. You may not have to let people go, but when there is natural attrition, the best question is to ask: “Do you really need to back fill that position?” In many cases, those duties can be spread among the employees you already have. This will obviously decrease overhead cost.

When there is natural attrition, the best question is to ask: “Do you really need to back fill that position?” In many cases, those duties can be spread among the employees you already have. This will obviously decrease overhead cost.

The second question that a practice owner or manager should ask is whether the employees you have are optimizing their time on the job. Do you have a lot of overtime pay? If so, it is critical to ban overtime, except when it is approved in advance. It’s amazing how most people get more efficient when they are busy and tend to develop lazy habits when they are not. Just knowing they have to finish their work by the end of their shift because they will not get paid for overtime is a strong incentive for increased efficiency.

Along this line is how many salaried employees you have versus hourly pay workers. It is advisable that only critically needed personnel receive a salary, especially those that would possibly generate a lot of overtime in order to perform their duties, such as the office manager. Increasing someone’s salary is the cost that just keeps on going, so offer bonus pay instead of large salary increases as an alternative.

The third question is to critically analyze how productive...
and profitable your providers are for the practice. Providers are the revenue generators for your practice, but they are also the most costly of your employees. Do you know how many patients each one needs to see per day/week/month in order to cover the cost of doing business? This is called the “break-even” point. There are many formulas available to generate this number, however you must know your total overhead cost per full time equivalent (FTE) provider as well as the average charge per patient and your practice collection percentage. If the overhead cost per day is $200 and you receive $10 remuneration per patient, the break-even number would be 20 patients per day just to cover costs. In other words, a provider would need to see more than 20 patients per day in order for the practice to be profitable.

SUPPLIES
The next area of overhead cost that needs to be evaluated is medical and office supplies. It is obvious that a practice has ongoing needs for supplies in order to provide services for patients but tight management of inventory is critically important. Having 10 boxes of exam gloves in each size in the storage closet is fine, but having 10 cases of gloves in each size is just storing money on the shelf. Make sure that time sensitive supplies are used first and ordered judiciously. Throwing away expired products (such as vaccines and injectable medications) is throwing money away, so don’t order more than you will reasonably use. Also, critically analyze whether you use a medication or vaccine often enough to justify keeping that investment sitting around in your office. It is also helpful to know how quickly your practice can get resupplied in order to never run out of critical inventory. Lastly, to streamline the ordering process and avoid over-ordering, assign just one person to manage supplies for the front desk and another for the clinical area (a very small office could have one person managing both).

While on the subject of supplies, you should shop around for the best prices. There are many vendors available to supply your office (remember to check online as well) and you can certainly have more than a single supplier. Don’t feel obligated to use a company just because you’ve been their customer for years and you like their sales representative. This isn’t personal, it’s business! The funny thing is that when you start shopping around, often the deals from your old stand-by get better. Additionally, there are also volume purchasing arrangements between multiple medical practices. There may be one in your area, so check around.

PURCHASED SERVICES
The last section on overhead that deserves attention is all of the goods and services that your practice purchases. Are you happy with the companies that provide services to your practice such as janitorial, printing, and accounting? Do you know which of your advertising venues are most successful for your practice and provide the best return on investment for you? If you regularly provide lunch for staff meetings, can you ask everyone to brown bag their own meal? Have you considered rewarding staff members for helping you economize and save money for the practice? Employees respond positively when they know that raises and bonuses depend on the practice controlling overhead cost.

The most important quality of a medical practice is to stay profitable. Top of the line equipment is expensive and attracting new medical talent involves a considerable investment. No matter that your practice delivers the very best care to your patients, if you are not profitable, you won’t be around very long to deliver that excellent care. By carefully managing your overhead, your bottom line will undoubtedly improve.

Rebecca R. Fox MD has been caring for children in Loudoun County for 23 years in general pediatrics. She is opening her new practice to focus on integrative and functional medicine concepts for pediatric patients. She is especially interested in centering her care on the special needs of complex medical conditions such as POTS, PANDAS/PANS, Lyme disease and ADHD.
IT’S TIME FOR MACRA

Is your practice ready for the new Medicare payment systems coming in January 2017? Now is the time to develop a plan.

BY ERICA SPREY
he 2016 Physicians Practice Physicians Compensation Survey shows that few doctors are being compensated for value-based care. Of 1,095 responding physicians, 67.6 percent say none of their compensation is tied to value-based care, and another 16 percent say it’s less than 1 to 5 percent.

The 2016 Physicians Practice Physicians Compensation Survey shows that few doctors are being compensated for value-based care. Of 1,095 responding physicians, 67.6 percent say none of their compensation is tied to value-based care, and another 16 percent say it’s less than 1 to 5 percent.

Moreover, a clear majority or 72 percent say none of their compensation is tied to patient satisfaction metrics.

That will change, whether physicians like it or not. Medicare’s new value-based reimbursement program is slated to begin in January 2017, with payment adjustments set to take place in 2019. CMS released its final ruling concerning the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) in mid-October 2016, which will compensate physicians for quality-based metrics and patient outcomes under the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Model (APM) pathways. Yet, many industry experts say that a good number of physicians are not even sure what MACRA is, let alone willing to accept the paradigm shift that it requires.

Susan Madden, founder and CEO of The Verden Group, a practice management consulting firm based in Nyack, N.Y., says physicians just don’t understand the push to embrace value-based care. “When we talk about value, it’s sort of ‘value for who?’” she says. “Payers understand value because they are trying to get quality and outcomes for the amount of money that is being spent on healthcare. Physicians don’t see it in the same way.”

While it is easy to speak about bringing value, controlling cost, and improving quality of care for populations of patients, physicians are more intimately concerned with caring for each patient individually. This can set up an adversarial relationship with policymakers, economists, and even payers who are looking at healthcare more in terms of dollars and cents.

“The value is very cognitive, for most physicians, because it is about the relationship with the patient,” says Madden. “So we are really talking about two radically different things from the perspective of each of the key players in this. … [Physicians] are very physical, very tangible, not very economically focused and driven in the way that payers are,” she says.

W HY ARE PHYSICIANS RESISTANT TO VALUE-BASED CARE?

In our survey, only 30 percent of respondents say they expect their compensation will be lower in 2019 because of the changes that MACRA will bring, and 60 percent say they are not sure how MACRA will affect their practice revenue. While the government has essentially eliminated the negative payment adjustment in the first year that Medicare uses its new compensation formula (as long as physicians report a small amount of data in 2017), that will not be the case in subsequent years.

Ellis “Mac” Knight, senior vice president and chief medical officer for Coker Group, a consulting firm based in Alpharetta, Ga., says physician resistance to MACRA may stem from an intrinsic view of medicine and patient care that is still firmly rooted in a fee-for-service (FFS) model. During the many years that Knight was a practicing internist and hospitalist, he says he foresaw “changes coming down the pike” stemming from health-care reform and the movement to value-based reimbursement.

In his last role with Palmetto Health system in Columbia, S.C., he helped develop a Clinically Integrated Network (CIN) composed of the health system and roughly 600 community physicians, because he says he believed that the current system
was not providing high-value care for patients or positioning physicians to thrive in a value-based environment. He admits that his position is not popular with the majority of physicians because, “Most physicians are so close to and so accustomed to practicing in a [FSS] environment, that they can’t really see the perversities, if you will, that this payment model has caused,” he says. “All healthcare providers, I would have to say, are fairly myopic in terms of their vision of the industry as a whole. They see themselves very interested in quality, they see themselves as very cost efficient, and they really don’t see the broader picture that those two things aren’t really true.”

WHAT DOES MACRA MEAN FOR SMALL, INDEPENDENT PRACTICES?
The value-based payment programs created under MACRA are designed to be budget neutral, meaning there is essentially a fixed pot of money for Medicare reimbursements beginning in 2019. In other words, if some physicians receive bonus money, others will receive a negative payment adjustment. The value-based payment programs created under MACRA are designed to be budget neutral, meaning there is essentially a fixed pot of money for Medicare reimbursements beginning in 2019. In other words, if some physicians receive bonus money, others will receive a negative payment adjustment. According to the Quality Payment Program Overview Fact Sheet released by CMS, if a physician decides to participate in MIPS, then he will see either a positive, neutral, or negative payment adjustment of up to 4 percent of his Medicare payments (based on 2017 performance) in 2019, depending on the amount of quality-based data he provides.

There are exceptions to this provision: if a provider has fewer than 100 Medicare patients, or bills less than or equal to $30,000 in Medicare charges, he is exempt from participation in MIPS.

Due to physician concerns during the final rule comment period, CMS has provided for a “transition year” starting Jan. 1, 2017, that eases reporting requirements and allows physicians to “pick their pace of participation.” For instance, if a physician simply desires to avoid a negative payment adjustment in year one, she can start collecting performance data by Oct. 2, 2017 and submit a minimal amount of data to Medicare by March 31, 2018 — e.g., one quality measure or one improvement activity.

However, the reporting requirements will increase in year two, so doing the bare minimum is simply kicking the can down the road. Madden suggests that physicians use the transition year to familiarize themselves with new reporting requirements and quality metrics. “Don’t wait, because you can take baby steps, January through October, and then test it out and see what that looks like for you in terms of monitoring your care and reporting on some of these categories,” she says.

KrisEmily McCrory, an employed, family-medicine physician based in Schenectady, N.Y. As a board member for her state chapter of the American Academy of Family Physicians, she also advocates for physician political activism, especially when it comes to concerns over changing government regulations and practice conditions for physicians and their patients. She has expressed grave concerns about the challenges and burdens that MACRA will place on smaller physician practices.

After Medicare makes the first payments under MIPS, McCrory asks, “How many people are going to drop Medicare at that very moment? That, I think, is going to be very telling. You are going to find out in 2018 if you are going to have a negative payment adjustment. And if you are going to have a negative adjustment, is it worth taking Medicare patients anymore? We are not going to know that unintended consequence until we get through the first year.”

Small practices have fewer resources than larger groups — staff, technology, and financial reserves — to help them address new reporting measures and needed changes to clinical work flows to support participation with MIPS, says Knight. If practices do try to go it alone, he says, they must first ask themselves, “What type of IT infrastructure am I going to need? What data systems am I going to need to report all these performance metrics? What billing
systems am I going to need to put that into place, or get someone to outsource for me, so that I can get adequately reimbursed for value-based care?"

**WHAT SPECIFIC STEPS SHOULD PRACTICES TAKE TO PREPARE FOR MACRA?**

Many physicians are already participating in federal programs that are now part of MIPS; they’ve just been given new names. The EHR Incentive Program, or Meaningful Use, has been renamed the Advancing Care Information performance category under MIPS, which counts for 25 percent of the category weight in 2017. Most physicians will need to fulfill five measures in this category for at least 90 days (if they have chosen to report data for a full year in 2017): security risk analysis, e-prescribing, provide patient access, send summary of care, and request/accept summary of care.

“If practices, particularly independent practices, have already started doing Meaningful Use, if they’ve already started taking steps to become a certified Patient-Centered Medical Home (PCMH), they’re in the best shape,” says McCrory. “People who have somehow managed to not get an EHR are in really tough shape.”

Another consideration is the requirement that physicians must use an approved EHR that has been certified in 2014 for first year MIPS reporting, which could necessitate a significant investment in funds to upgrade or replace old technology. Madden says now is the time for practices to assess their current technology and ask if it is capable of reporting the data and quality measures required for MIPS. If not, practices should not wait on making new IT investments. It can take up to six months to thoroughly research, vet, and choose a new EHR system, she says.

Practices that are currently — or have taken steps to gain accreditation as — a PCMH are in a much better position in terms of demonstrating quality measures for MIPS, says McCrory. They are also more at home using technology for reporting purposes. “Participants in certified Patient-Centered Medical Homes, comparable specialty practices, or an APM designated as a medical home model, will automatically earn full credit” for the new Improvement Activities performance category, according to CMS. For practices that are not medical homes, Madden recommends they focus their energy on learning about Improvement Activities so that they can familiarize themselves with the new category, since it counts for 15 percent of the category weight in 2017.

The Physician Quality Reporting System (PQRS) program has been replaced by the Quality performance category under MIPS, which accounts for 60 percent of the category weight in 2017. When it comes to quality, “most Medicare providers have been reporting through Medicare’s (PQRS),” says Madden. “They are fairly familiar with what the quality measures are and how they need to report on them.” McCrory recommends that practices review the PQRS report from 2014 (the 2015 report will come out soon) so that they are aware how well they are doing on quality measures like patient HbA1Cs, compared to national standards.

The final performance category, Cost, replaces the Value-Based Modifier and will not be counted into the final score for MIPS until 2018. For this measure, practices will not be required to submit data. It will be calculated from adjudicated claims data.

**WHAT ARE SOME OTHER ACTIONS PHYSICIANS CAN TAKE?**

Aside from becoming employed or dropping Medicare altogether, a third option for physicians is to join forces with other practices via Accountable Care Organizations (ACOs) or a CIN, says Knight. These types of structures can allow practices to operate independently, yet still benefit from economies of scale when it comes to administration, reporting, technology, contracting, and billing.

A strong advantage of joining a CIN is that the organization is already structured to focus on improving quality of care and decreasing cost via measuring outcomes and using them in data driven process improvement.

These value-based tenets will prepare physicians for participation in MIPS or APMs, according to Knight. “The roll out of MACRA is going to hasten … the interest of most independent providers to either become employed or to band together under APMs like CINs or ACOs, and offload or at least share the responsibility for this reporting burden and these change activities with a larger entity,” he says.

“At the end of the day, you can run but you can’t hide,” Knight declares. “I think [physicians] are going to have to face up to the fact that a lot of what we do is waste and inefficient, and not necessarily value add … This is the whole purpose that CMS is trying to drive, [doctors] can look at their practice patterns and say, ‘What can we do to reliably deliver measurable, high-quality outcomes, and do that in the most cost-efficient manner possible?’”

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Erica Sprey is associate editor for Physicians Practice. She can be reached at editor@physicianspractice.com.
IN WHICH OF THE FOLLOWING SPECIALTY AREAS DO YOU WORK?

- Internal medicine, or non-surgical specialty other than OB/GYN (73.5%)
- Surgery (17.0%)
- OB/GYN (9.5%)

WHAT TYPE OF PRACTICE ARE YOU IN?

- Solo (24.8%)
- Group, 2-5 physicians (31.0%)
- Group, 6-10 physicians (12.7%)
- Group, 11-20 physicians (7.1%)
- Group, more than 20 physicians (20.2%)
- Other (please specify) (4.2%)

HOW MUCH DO YOU PAY ANNUALLY FOR MALPRACTICE INSURANCE?

- (Internal medicine, or non-surgical specialty other than OB/GYN)
  - Less than $15,000 (24.5%)
  - More than $15,000, less than $50,000 (38.6%)
  - More than $50,000, less than $100,000 (11.6%)
  - More than $100,000, less than $150,000 (1.7%)
  - More than $150,000, less than $200,000 (0.9%)
  - More than $200,000 (2.6%)
  - Don’t know (34.8%)

(Internal medicine, or non-surgical specialty other than OB/GYN)
  - Up to $7,000 (17.6%)
  - More than $7,000, less than $10,000 (16.9%)
  - More than $10,000, less than $15,000 (18.1%)
  - More than $15,000, less than $20,000 (7.6%)
  - More than $20,000 (5.0%)
  - Don’t know (34.8%)
WHAT WAS YOUR INCOME LAST YEAR, INCLUDING ANY CASH OR CASH-EQUIVALENT BONUSES, BUT NOT INCLUDING INSURANCE AND OTHER NON-CASH BENEFITS? (Based on full-time equivalency)

- $100,000 or less (5.1%)
- $100,001-$125,000 (2.7%)
- $125,001-$150,000 (5.1%)
- $150,001-$175,000 (6.2%)
- $175,001-$200,000 (13.0%)
- $200,001-$250,000 (19.5%)
- $250,001-$300,000 (13.1%)
- $300,001-$350,000 (10.1%)
- $350,001-$400,000 (6.2%)
- $400,001-$450,000 (4.5%)
- More than $450,001 (14.5%)

HOW MUCH OF YOUR COMPENSATION IS TIED SPECIFICALLY TO PRODUCTIVITY:

- None (32.2%)
- 1%-10% (11.5%)
- 11%-25% (7.2%)
- 26%-50% (4.1%)
- 51%-75% (5.6%)
- More than 75% (9.7%)
- All of it (29.7%)

WHAT PERCENTAGE OF YOUR INCOME CAME FROM SOURCES OTHER THAN GUARANTEED SALARY?

- None (31.3%)
- 1%-10% (17.8%)
- 11%-25% (12.0%)
- 26%-50% (4.9%)
- 51%-75% (4.2%)
- More than 75% (5.2%)
- All of it (24.6%)
How did your personal income last year compare with the previous year?

- It was down by more than 10% (16.7%)
- It was down by more than 5%, less than 10% (7.2%)
- It was down by less than 5% (4.8%)
- It was about the same (39.5%)
- It was up by less than 5% (12.4%)
- It was up by more than 5%, less than 10% (9.4%)
- It was up by more than 10% (10.0%)

What was your practice’s overhead (i.e. the cost of doing business — rent, utilities, salaries, etc.,) as a percentage of medical revenue?

- 1% - 10% (9.8%)
- 11% - 20% (6.7%)
- 21% - 40% (22.0%)
- 41% - 60% (40.4%)
- 61% - 80% (15.1%)
- 81% - 100% (3.8%)
- 101% or more (2.2%)

Is that greater than, less than, or the same as it was one year prior?

- Greater than last year (32.0%)
- Same as last year (63.5%)
- Less than last year (4.5%)

Which of the following best describes net income from your practice?

- Excellent: 10.7%
- Pretty Good: 23.4%
- About Right: 21.1%
- Slightly Disappointing: 30.4%
- Highly Disappointing: 14.3%
How do you think your practice will do financially over the next year?

**Better (25.6%)**

**Worse (24.8%)**

**About the same (49.6%)**

In the next year, I plan to:

(Select all that apply)

- Continue as I am (66.7%)
- Become employed by a larger health system (10.5%)
- Seek a partnership / group opportunity (9.9%)
- Retire (6.6%)
- Close/sell my practice (5.0%)
- Transition to a direct-pay, concierge, or hybrid concierge practice (4.3%)
- Join an ACO (4.2%)
- Other (please specify) (10.0%)

How has your practice been affected by high-deductible insurance plans?

- We are having a harder time collecting larger patient copays and deductibles (56.3%)
- A limited number of our patients have high-deductible health plans (20.3%)
- We have not experienced any changes in patient collections (14.8%)
- Other (please specify) (8.6%)
PLEASE IDENTIFY YOUR EMPLOYMENT:

- I'm an owner/partner of my practice (46.0%)
- I'm an employed physician of a hospital/health system-owned practice (33.6%)
- I'm an employed physician of an independent practice (11.4%)
- *Other (please specify) (8.9%)

*Top Answer was Independent Contractor

WHAT IS YOUR SPECIALTY?

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Family Medicine/Family Practice</td>
<td>23.4%</td>
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<tr>
<td>Internal Medicine</td>
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<tr>
<td>Pediatrics</td>
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<td>Orthopedic Surgery</td>
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<tr>
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<tr>
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<tr>
<td>Oncology</td>
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</tr>
<tr>
<td>*Other (please specify)</td>
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</tbody>
</table>

*Top Answer was Ophthalmology

HOW MANY YEARS HAVE YOU BEEN IN PRACTICE?

- Less than 5 years (8.9%)
- 5-10 years (13.7%)
- 11-15 years (16.4%)
- 16-20 years (14.2%)
- More than 20 years (46.8%)
HOW MUCH OF YOUR COMPENSATION IS TIED SPECIFICALLY TO PATIENT SATISFACTION MEASURES?

- None (72.1%)
- 1% to 5% (15.2%)
- 6% to 10% (6.1%)
- 11% to 25% (3.1%)
- More than 25% (3.5%)

HOW MUCH OF YOUR COMPENSATION IS TIED TO VALUE-BASED CARE (QUALITY AND COST OF CARE PROVIDED)?

- None (68.0%)
- 1% to 5% (16.2%)
- 6% to 10% (6.4%)
- 11% to 25% (5.1%)
- 25% to 50% (1.8%)
- More than 50% (2.5%)

WHAT STEPS HAVE YOU TAKEN TO BOOST REVENUE AT YOUR PRACTICE? (select all that apply)

- Increased the number of patients seen per day (32.5%)
- None (31.1%)
- Marketing (22.5%)
- Taken on work outside of my practice (22.1%)
- Added ancillary services (20.5%)
- Adjusted payer mix (including dropping low-paying plans) (15.0%)
- Started charging for non-traditional care such as telemedicine (e-visits) or communication through patient email (4.9%)
- Started an in-house dispensary (3.6%)
- Changed to a direct pay, concierge, or hybrid concierge practice (2.6%)
- Other (please specify) (9.3%)
DOES YOUR PRACTICE ACCEPT MEDICARE?

**YES:** 82.5%

**NO:** 17.5%

HOW HAS THE UPCOMING CHANGES TO MEDICARE REIMBURSEMENT — MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) AND ALTERNATIVE PAYMENT MODELS (APMs) — AFFECTED YOUR WILLINGNESS TO CONTINUE ACCEPTING MEDICARE?

- Yes (49.4%)
- No (37.0%)
- Our state has refused to expand (13.6%)

ARE YOU SEEING MORE MEDICAID PATIENTS DUE TO ELIGIBILITY EXPANSION?

- It hasn’t; we plan to continue accepting Medicare as always (75.7%)
- We may stop accepting new Medicare patients (14.0%)
- We are exploring new direct-pay models that would eliminate third-party payers from our practice (5.4%)
- We may stop seeing/accepting Medicare patients altogether (4.9%)
IS YOUR PRACTICE ACCEPTING PATIENTS WHO PURCHASE INSURANCE PLANS THROUGH HEALTH INSURANCE EXCHANGES (ALSO KNOWN AS MARKETPLACES)?

YES: 79.6%  NO: 20.4%

WHAT IS THE MAIN REASON YOU ARE ACCEPTING THESE PATIENTS?

- A hospital/employer/insurer mandated us to do so (32.9%)
- We want to increase patient volume at our practice (30.4%)
- We feel that we are locked into an exchange plan via our payer contract (11.6%)
- We are looking to expand our payer mix (11.0%)
- *Other (please specify) (14.1%)

*Top Answer was “It’s the right thing to do”

WHAT IS YOUR BIGGEST ISSUE WITH THESE PLANS WHEN IT COMES TO YOUR REVENUE?

- I don’t have any issues (36.6%)
- Collecting patient payments (23.7%)
- Collecting payment from payers (17.3%)
- Patient seen once, then plan dropped, so we lose money (14.2%)
- Other (please specify) (8.2%)
PHYSICIAN INCOME TRENDS SHIFTING FAVORABLY FOR PRIMARY CARE

Primary-care physicians are still making less than subspecialists. Is that about to change in the shift to value-based care?

BY GABRIEL Perna

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hysician income is stuck in neutral. According to this year’s Physicians Practice Physician Compensation Survey, only 31.8 percent of physicians saw their salaries go up from 2015. In last year’s survey, this number was 31.7 percent. Moreover, nearly 40 percent of respondents say their personal income was about the same from last year, which was essentially identical to last year’s survey as well.

What about the difference between specialists and primary-care physicians? There is evidence suggesting that the gap in pay between primary-care physicians and specialty physicians is decreasing. Last year, 52.5 percent of family physicians made between $175,001 and $250,000 in income; this year that’s gone down to 45.8 percent. Meanwhile, the number of family physicians making $250,001 to $350,000 has gone up from 5 percent to 26.3 percent over the past year.

“Primary-care salaries have gone up. The demand is there, it has and will continue to grow. From our data … family practice is the number one searched physician specialty for potential jobs, which correlates to a higher demand,” says Kurt Mosely, vice president of strategic alliances for Irvine, Calif.-based physician recruiting firm, Merritt Hawkins, who says demand has increased the overall pay of these family physicians.

Yet, Mosely is quick to add, “There is still that gap.”

IS PRIMARY CARE UNDERPAID?

Indeed, while family-medicine physicians say they are bringing in more money than in the past few years, medical specialists are still in the upper echelon of income when compared to other physicians. For instance, of the surgical specialists who answered the compensation survey, nearly 40 percent said they make more than $450,001 per year — which was by far the highest salary tier for any specialty. Only 2.3 percent of responding family-medicine physicians made that much.

Will Latham, a Chattanooga, Tenn.-based consultant who advises practices on compensation structure, says that primary-care physicians saw small increases in pay during the 1990s and the early days of Medicare’s resource-based relative value scale (RBRVS). However, he says, over time those financial gains slowed down for primary-care physicians, while specialists, with a major leg up from their advocacy groups that petitioned Congress for better Medicare reimbursement, continued to see increased compensation.

He adds that medical specialties benefit from “big-ticket items,” such as MRIs or CT scans, which can be additional avenues of income, whereas primary-care physicians don’t really have that. “Most family physicians realize they have to see a [certain] volume of patients to generate income, five to 10 minutes is what they are shooting for. It’s a short period of time,” Latham says.

William Creevy, a Boston-based orthopaedic surgeon as well as the vice chair of the American Association of Orthopaedic Surgeons’ (AAOS) Coding, Coverage, and Reimbursement Committee, says that primary-care physicians also do a lot of work that doesn’t get reimbursed. “If the patient calls and you spend 15 minutes on the phone explaining and answering their questions, although there are CPT codes that describe doing work over telephone, hardly any insurance companies recognize that. There is a lot of work coordinating care, doing these phone calls, reviewing things, it’s extra work but there is no reimbursement for it. Good primary-care physicians do this every day,” he says.
John Meigs Jr., a family-medicine physician in Centreville, Ala., and president of the American Academy of Family Physicians, leaves no doubt on the topic of whether primary-care physicians are underpaid compared to other medical specialties. “Certainly, there’s research be a shortage of up to 31,100 primary-care physicians by 2025.

However, Matthew Schick, senior legislative analyst at AAMC, says money isn’t the main issue. He says AAMC’s analysis has found, when picking a specialty, medical school graduates aren’t looking at income potential and debt so physicians’ career decisions. After all, according to the New England Journal of Medicine, the difference in income over a 35-year to 40-year career between subspecialists and primary-care physicians is $3.5 million. “I think people do [look at potential income], probably students, particularly if they are incurring substantial debt. Your ability to pay off debt is going to be different if you are an orthopaedic surgeon with a proposed income in the low [$400,000 range] compared to primary care, where it’s less than half of that,” Creevy says.

In that regard, Meigs says in order to increase the number of medical students going into primary care, they have to be exposed in medical school to the breadth, complexity, and engagement that family medicine physicians have with their patients. They also have to be paid appropriately. “It’s got to start with the right people getting into medical school, the right exposure in medical school, and appropriate payment for the value we bring into the system,” he says.

out there, there’s data that shows that family physicians provide the most complex care of any medical specialty. We bring value to the system,” he says. “The problem in our current fee-for-service system ... [is] it rewards volume more than value.”

**THE POTENTIAL OF VALUE-BASED CARE**

If it seems the word value keeps coming up in connection with primary-care physician compensation, there is a reason why. Experts conclude that through the shift to value-based care payment models, primary-care physicians are going to see a bigger piece of the revenue pie. Specifically, Medicare reimbursement under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will lead the charge, they predict.

“MACRA begins Medicare’s transition from volume-based payment to value-based payments. MACRA is a complex law; it’s not perfect. But it does
begin the shift toward recognizing team-based care and payment for non-face-to-face services, care coordination, and efficient, high-quality healthcare,” says Meigs, who adds that when medical students see the prominence of primary-care physicians in this value-based environment — including an increased

his fellow specialty doctors will be less in demand. While their income may not go down as much, he says there will be less need for specialists overall. “Let’s say people cut down on the number of MRIs they do, I don’t think you’ll see radiologists making less money; I think you’ll see less radiologists. That

vice for primary-care physicians frustrated with any income-related issues, whether it’s on their own or in relation to how much specialists make.

“it’s good to sit down with your fellow physicians first … be open about it,” he says. “If you do want to renegotiate compensation, do your homework on what other doctors are making in your area. Are relative value units being compensated the same in your group compared to others in the state?” This transparency, he says, can help physicians negotiate with administrators, payers, and other important stakeholders.

For those who are solo, Latham advises there is strength in numbers. He recommends independent and small group practices merge or at least band together as an independent physician association. He also advises physicians to support advocacy groups that can lobby Congress for higher Medicare incomes for their specialty.

Schick at AAMC says there are opportunities for primary-care physicians to get involved with loan repayment programs, especially if they practice in a rural and underserved areas. This can curb any concerns they might have over debt and less pay for primary care. He also says look at the big picture.

“From my own perspective, at some point while income is important, you have to be happy. It’s looking at work-life balance, it’s looking at what you’re going to do on a daily basis and making sure it’s not just something you are comfortable with, but that’s going to bring you back into the door every day.”

—Matthew Schick, AAMC

income — they’ll be more likely to choose that career path.

Merritt Hawkins’ Mosley agrees and says it’s already started to happen. “… as we go to value-based care, if [physicians are] in a Patient-Centered Medical Home (PCMH) … there is a chance for them to make more money than they ever have in the past [for coordinating care],” he says. “Value-based care is centered around primary-care [physicians] because they are the first point of contact.”

Value-based care will lead to more than just an increase in primary-care income, Creevy says. He predicts that he and sort of supply and demand is truly a market force,” he says.

Even with MACRA on the horizon, this shift is still a work in progress and most physicians are still not seeing any returns from value-based care. According to the Physician Compensation Survey, 67.6 percent of respondents say none of their compensation is tied to value-based care, while another 16 percent say only 1 percent to 5 percent of their compensation is tied to value.

ADVICE

How much that will shift in the near future is anyone’s guess. In the meantime, Mosley has ad-

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KEEPING MEDICAL PRACTICE OVERHEAD DOWN

In light of rising costs to do business, physicians are looking for ways to cut costs while sustaining quality patient care.

BY KAREN APPOLD

According to the 2016 Physicians Practice Physician Compensation Survey, 40.4 percent of survey respondents said their overhead is 41 percent to 60 percent of medical practice revenue. In comparison, 32 percent of respondents from last year’s survey cited the same percentage of overhead. That means, over a period of one year, 8.4 percent more survey respondents said they were experiencing overhead costs that were close to or exceeding half of their practice revenue.

“Expenses related to goods and services always seem to go up, such as employee salaries, rent, utilities, and supplies,” says Steven Fisher, an internist at Fairfield County Medical Group in Trumbull, Conn. “Therefore, the cost of doing business goes up. But unlike most businesses that can pass along increased expenses to consumers, primary-care physicians can’t do that because of governmental regulations and the way that health insurance companies operate.”

Paying staff to perform administrative duties probably tops the list of overhead expenses.

“Physicians and their staff spend a growing amount of time ensuring that quality and performance measures are collected, documented, and reported,” says Marc Mertz, vice president of El Segundo, Calif.-based GE Healthcare Camden Group. “Due to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), requirements will continue to increase. Practices have also invested in EHR systems that support data collection and reporting, resulting in more administrative work.”

What’s more, “primary-care physicians are tasked with providing referrals and getting pre-authorizations for diagnostic testing and prescriptions,” Fisher says. “In addition, given that many health plans now have high deductibles, practices have to chase patients to pay for services — sometimes billing them multiple times. In the past, insurance companies paid them directly.”

LOWERING OVERHEAD

According to the survey, overhead is going up while personal income is staying the same (40 percent) or going down (28.7 percent). So what can practices do to keep overhead down?

Fisher recommends examining every line item on your profit and loss statement, and seeing where you might be able to spend less or where you might be wasting money. For example, you can shop around for better prices on malpractice insurance. Physicians at Fisher’s practice saved $5,000 on malpractice premiums, and gained CME credit by taking courses on reducing malpractice risk that were offered by the insurer.

Another strategy Fisher’s practice employs is requiring all patients with high-deductible plans to keep a credit or debit card on file. “This way, we don’t have to bill patients; instead, we can charge their card,” he says. “We always collect everything we’re entitled to while keeping administrative costs down. If a patient doesn’t want to provide a card, he is required to pay the estimated amount of the visit at the time of service or he can’t be a patient. Most patients don’t have a problem with this because we explain that this keeps costs down by not having to bill and re bill them.”

Charlene K. Mooney, a consulting executive with Halley Consulting Group, a practice management and consulting firm in Columbus, Ohio, is also a proponent of implementing a policy to collect payments at the time of service. “Train staff how to ask for money, since this can be uncomfortable, yet effective,” she says. “Don’t ask ‘Do you want to pay your copay today?’ Instead, say ‘Your copay is this amount. How would you like to pay it today? We take cash, check, or credit card.’”

Mooney also recommends
ask staff to offer suggestions and help create a plan of action for patient collections. “Without [staff] buy-in, it can be difficult to bring about improvement,” she says.

Take a good look at your office — are you using all available space? Could you use more space? If you can afford to expand your office, perhaps you could add another exam room or sublease some space to another provider, Mooney says. She also suggests tracking charges from companies that provide equipment, supplies, and services — such as laundry or waste management. “Periodically look at renegotiating the contract or even checking out other [service] providers,” Mooney says. “If you need equipment, leasing versus purchasing may be more economical.”

When hiring staff, make good decisions so that you don’t have to incur turnover costs, Mooney says. Cross-train employees so when absences occur, staff can fill in for each other. Then, employ measures to retain good staff members by making sure that you offer a pay scale and benefits package that is competitive with your market.

“Consider ways to decrease [staff] health insurance costs, such as increasing deductibles, co-pays, or premiums, or making adjustments in types of coverage,” Mooney says. INCREASING REVENUE

One way to boost your revenue is to retain existing patients. In order to achieve this, you must offer outstanding customer service. “Every staff member from the receptionist to the provider must be committed to serving each patient to their best ability — making them feel welcome, communicating with them at every encounter, and providing quality care and treatment,” Mooney says.

Consider adding advanced practice providers. A nurse practitioner or a physician assistant can increase patient volume and free up physicians to see more complex patients, Mooney says. Another strategy to get more money coming in is to assess your scheduling methods. “Optimize time slots to reflect a good flow of patients,” Mooney says. “Training your staff to schedule more effectively is beneficial.”

It’s also important that patients keep their follow-up appointments. “Have someone make sure patients who need regular appointments for testing, bloodwork, and medication refills come in as necessary,” Mooney says. “Call no-shows to make sure they know they missed an appointment and reschedule them.”

Another tip is to offer new services. “Adding imaging and laboratory services can provide convenience as well as eventually bring in additional revenue,” Mooney says. Furthermore, consider performing in-office tests, such as hearing, asthma, and drug screens.

Michael Munger, president-elect of the American Academy of Family Physicians, and practicing family physician at Saint Luke’s Medical Group in Overland Park, Kan., advises making sure you code for as many services and procedures as possible. For example, make sure Medicare patients receive an Annual Wellness Visit every year, which is a reimbursable service through CMS. When seeing a patient following a hospitalization, use a code for transitioning of care.

SURVIVING AS AN INDEPENDENT PRACTICE

With medical practices facing such high overhead, independent practices are finding it more challenging to survive. “We’re already beginning to see the impact of rising overhead and population health/value-based reimbursement on independent practices,” Mertz says.

Mertz says small practices that cannot afford to invest in information technology, reporting, and other population health capabilities are at a disadvantage as more of their...
revenue is placed at risk under performance and value-based contracts.

John Meigs, Jr., president of the American Academy of Family Physicians and practicing family physician at Bibb Medical Associates, Centreville, Ala., believes that some physicians left independent practice for employed practice due to the uncertainty of transitioning from volume- to value-based payment as required by MACRA, because they desired the stability of employed status. “However, after the transition and when family physicians are paid commensurate with the value they bring to the healthcare system, then I think some physicians and practices will opt to return to independent practice,” he says.

Munger is also optimistic. “Moving forward, it will be helpful when independent practices, particularly small ones, start to receive payments for care coordination,” he says. Care coordination involves managing Medicare patients with chronic conditions, which includes the transition of care from a hospital or another healthcare facility to a community setting. It also involves advance care planning for Medicare beneficiaries whose medical and/or psychosocial problems require moderate- to high-complexity medical decision making. “As primary-care practices evolve and incorporate these services into their infrastructure, payment will follow,” Munger says.

TRADITIONAL INDEPENDENT PHYSICIAN MODELS CHANGE
Looking ahead, Mooney expects more independent practices to become affiliated with other groups or practices. “It might be beneficial for a practice to enter into a contract with a hospital or health system to provide services,” she says.

Along these lines, Munger says, “I think there will be opportunities for independent practices to develop population health service organizations that can support smaller practices with cost-effective solutions that will help them survive under value-based care models.”

Munger advises looking for contracting opportunities that provide financial incentives for reporting quality and performance measures. “Joining a network, such as a clinically integrated network, can help a group access these contracts,” he says. “Clinically integrated networks can also provide some of the population health tools and resources that a group needs to be successful under these contracts, often at a lower rate than the group would otherwise pay.” Also, be sure to look into CMS’ new payment models, such as Comprehensive Primary Care Plus (CPC+) and Chronic Care Management (CCM) services, which provide enhanced primary-care reimbursement.

Munger also sees strength in numbers, and predicts that independent practices will develop partnerships and networks revolving around quality of care. This might be through an arrangement with an independent practice association, in which a practice could associate with other independent practices to leverage economies of scale for contracting. Practices might also join together to increase their power to purchase supplies at discounted rates or obtain better rates for employee benefits.

There’s also been a shift toward a direct primary care model. Meigs points to a 2015 survey by AAFP that reports nearly 3 percent of independent family physicians said they opted to work within a direct primary care model. Another 1 percent said they were in the process of transitioning to direct primary care. “Direct primary care rewards family physicians for caring for the whole person while reducing overhead and negative incentives associated with fee-for-service, third-party payer billing,” he says. “Other benefits to physicians include fewer medical errors and less exposure to risk, improved practice collection rates, more time with patients, reduced patient volume, and zero insurance filing.”

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“We’re already beginning to see the impact of rising overhead and population health/value-based reimbursement on independent practices.”

—Marc Mertz, consultant