VIEWPOINT

Getting paid? What a concept

As Medicare reimbursements shrink, you must think outside the box

By MICHAEL McBRIDE, Technology Editor

I am in my 50s, so I remember when physicians were considered "highly paid." I recall being denied office visits on Wednesdays because my doctor was on the golf course making up for seeing patients on Saturdays. I can still hear the words of some who jealously decried that physicians made too much money. Those days, however, are long gone.

These days, I try to describe to my nonphysician friends and family members what it's like to work as a doctor by asking them to imagine their own bosses coming to them and saying, "Next year, we're planning to pay you 35% less than you made this year. But you have to keep up your same workload.

"In fact, you'll have to do more work than you did before. Because we're also planning to make you record and report everything you do—on tools you've never used, which aren't working all that well—to get paid. Have a nice day."

They hear me, of course, but they really don't get it. How can they? How can anyone? No one outside of the medical industry really understands what it's like to be a doctor. To be expected to make life-and-death decisions and then to be constantly second-guessed. To be trained to work autonomously and then have your every move scrutinized. To have to generate reports on everything you do while being expected to care for more patients—on less income—year after year.

It's a wonder anyone wants to be a physician at all. Which begs the question: Why *do* you want to be a doctor?

WHY PRACTICE MEDICINE?

Practicing medicine no longer offers physicians the cushy, upper-class life it once did. In fact, it has become one of the hardest, least rewarding jobs on the planet. So what is it that makes folks like you decide to keep on treating patients under today's grueling conditions?

The answer, I believe, is that you practice medicine because you must. It's how you are built. You're driven to treat patients, to keep or make them healthy, and to give them a chance at a good life free of disease or debilitating injuries. And thank goodness you do.

MEDICARE REIMBURSEMENT VERSUS DOCTOR'S SALARY

You and your colleagues in primary care are intimately familiar with the gap between reimbursements received from Medicare (and other health plans) and the salaries doctors take home after paying staff paychecks and covering office overhead. The distinction between physicians' reimbursements and their salaries, however, is mostly lost on the general public. And sometimes, qualified research (although technically accurate) confuses the issue even further.

For example, the Medical Group Management Association's "Physician Compensation and Production Survey" for 2012, which is based on 2011 Data, reported that median compensation for PCPs will increase by 5.16% under the Affordable Care Act (ACA). The survey is correct, but the data aren't referring to physi-

WHAT PRIMARY CARE PHYSICIANS EARN*

	Mean	Standard deviation	25th percentile	Median	75th percentile	90th percentile
Family medicine without obstetrics	$217,724	$82,522	$164,168	$200,114	$254,403	$322,586
Internal medicine – general	$236,392	$100,633	$174,983	$215,689	$274,870	$351,637

* Based on responses from 5,765 family physicians in 722 practices and 4,083 internists in 516 practices.
Source: MGMA Physician Compensation and Production Survey: 2012 Report Based on 2011 Data

cians' actual salaries, which likely will decline—dramatically.

Matthew Mintz, MD, associate professor of medicine at George Washington University, explained the reason in a recent *KevinMD.com* blog titled "Primary care doctors are set to lose more than half of their salary."

Mintz has been practicing internal medicine for more than 10 years. He is the respiratory editor of *Redi-Reference Clinical Update*, a biweekly clinical newsletter for PCPs, and is a peer reviewer for *American Family Physician*, the *Journal of Family Practice*, *Mayo Clinic Proceedings*, and the *Journal of General Internal Medicine*.

Mintz calculated that a 5-day-a-week solo practitioner who sees 25 patients each day brings in approximately $431,062 at the rate of $68.97 per visit. After subtracting 60% of that amount for practice overhead, Mintz calculates that the physician in that practice takes home approximately $172,425 annually.

This amount closely matches the $175,000 to $199,000 median salaries the family practitioners participating in *Medical Economic's* 2011 Physician Earnings Survey reported for 2009 and 2010 (see www.MedicalEconomics.com/2011earnings; an upcoming issue of *Medical Economics* will feature data from the 2012 Physician Earnings Survey).

Here's where it gets painful: If the Centers for Medicare and Medicaid Services' (CMS') 27.4% reduction in Medicare physician reimbursement goes into effect, that $68.97 reimbursement per visit will decrease to a little more than $50, thus reducing the practice's annual revenue to less than $320,000. Without corresponding reductions in staff salaries and practice overhead, the difference can only be recouped from the physician's salary, which drops from around $172,000 to about $60,000.

Mintz believes that if these cuts in Medicare reimbursements come to pass, doctors will either stop accepting new Medicare patients or will stop seeing Medicare patients altogether. So it's clear why you might balk at purchasing expensive electronic health record systems when the entire future of your medical practice is at risk.

Recent health reform initiatives provide opportunities for you to recover some of those losses and increase your income. It requires, however, that you keep an open mind about your practice's revenue.

INCREASE YOUR REVENUE WITH QUALITY REPORTING

Now that the Supreme Court has upheld the individual mandate of the ACA, one area that should be

CONTINUED ON **PAGE 53**

Medicare debate changes insurers

The debate over Medicare reform has dramatically altered how the commercial insurance industry operates, according to Jay Sultan, associate vice president and general manager for payment reform with the TriZetto Group. Sultan recently participated as an expert panelist in a *Medical Economics* Web seminar about how primary care physicians (PCPs) can take advantage of payment reform to increase their incomes.

According to Sultan, the way to understand the upcoming payment reforms and methodologies is to avoid becoming fixated on how the changes affect your payments.

Instead, he recommends that PCPs, "consider the opportunities and risks that will be introduced by the development of commercial accountable care organizations [ACOs], commercial medical homes, and commercial payment bundling programs."

Sultan says that the basis of these reforms has to do with "shifting risk from payers to different groups of providers."

He also suggests that the provider groups who are willing to accept more risk will have more control over "how the payments get made and who ends up essentially working for whom in the future."

"What PCPs need to understand," Sultan says, "is that for some of the organizations involved in these reforms, primary care is an expense to be managed, which, if I were a PCP, would scare the life out of me.

"And for others," he continues, "primary care is now really a delivery catchment zone. Their job is to get aligned with as many PCPs as they can as kind of a steerage mechanism. Or as a way of extending out into the primary care space a continuity-of care plan that encompasses hospital-based care and specialty care."

Sultan, however, believes that payment reform initiatives such as the Physician Quality Reporting System (PQRS) program offer PCPs many opportunities. He says PCPs should be asking:

- **How can we control our own future?**
- **How can we become the epicenter of these new care-delivery models?**
- **How can we take programs, such as patient-centered medical homes, and expand them so that *we* determine *how* care gets delivered, while also taking a more central role in how payments are made?**

Medical homes and ACOs have struggled with these payment models in the past. They may now, however, be our best hope for containing healthcare costs while promoting primary care.

By participating in these programs, you'll also be populating aggregate databases of patient information and demographics that fuel evidence-based medicine and point-of-care decision making.

In addition to increasing opportunities to effect quality outcomes for all primary care patients, you can earn additional revenue by recording and reporting the outcomes to the PQRS database.

Or, at the very least, you can maintain your current level of revenue.

CONTINUED FROM **PAGE 50**

of immediate concern to you is the quality reporting aspects of the legislation and how you can increase your revenue by participating in the Physician Quality Reporting System (PQRS) program.

Formerly known as the Physician Quality Reporting Initiative, or PQRI, the PQRS program combines incentive payments and payment adjustments to encourage eligible professionals to report quality-related information.

The Physician Quality Reporting System provides incentive payments to practices that satisfactorily report on quality measures for covered physician fee schedule services furnished to Medicare Part B fee-for-service beneficiaries.

The program provides incentive payments to practices that satisfactorily report data on quality measures for covered physician fee schedule services furnished to Medicare Part B fee-for-service beneficiaries, including Railroad Retirement Board and Medicare Secondary Payer.

If you're not working toward participating in the PQRS incentive program, you might consider starting soon. Quality reporting requires you and your staff to do extra work, but in addition to improving healthcare, there's also additional money to be made, and these days you need all you can get.

Send your feedback to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.

FOR MORE INFORMATION

Prepare for payment reform and increase your income today
www.MedicalEconomics.com/PaymentReformWebSeminar

Physician earnings remain flat
http://www.MedicalEconomics.com/2011earnings

Primary care doctors are set to lose more than half of their salary
http://www.kevinmd.com/blog/2011/12/primary-care-doctors-set-lose-salary.html

Physician Compensation and Production Survey 2012 Report Based on 2011 Data
http://www.mgma.com/store/Surveys-and-Benchmarking/Physician-Compensation-and-Production-Survey-2012-Report-Based-on-2011-Data-Print-Edition/

Medicare 27.4% doctor pay cut set for 2012 unless Congress acts
http://www.ama-assn.org/amednews/2011/11/14/gvl11114.htm#s1

Family Practice Doctor Salary
http://www.healthcaresalaryonline.com/family-practice-doctor-salary.html

Internist Salary
http://www.healthcaresalaryonline.com/internist-salary.html

Centers for Medicare and Medicaid Services Physician Fee Schedule Final Rule
http://www.ofr.gov/OFRUpload/OFRData/2012-16814_PI.pdf

Affordable Care Act
https://www.cms.gov/Regulations-and-Guidance/Legislation/LegislativeUpdate/downloads/PPACA.pdf

2012 EHR Web Seminar Series

WEB SEMINARS

Medical Economics is conducting monthly live Web seminars on the health information technology topics that affect you most:

- Complying with HIPAA 5010/ICD-10 implementation
- Digitizing your paper records
- Client/server, SaaS, and Web-based EHRs: What's the best fit for your practice?
- Preparing for payment reform to increase your income
- Attesting to meaningful use stage 1 in 2012–2013
- Cloud-based EHR privacy, security, and HIPAA compliance

Interact live with other physicians and have your questions answered by industry experts.

Participate in any or all of the Web seminars at no cost.
To learn more or to download previous offerings, visit www.MedicalEconomics.com/EHRWebSeminarSeries.