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BUILD FINANCIAL SUCCESS
4 ways to grow revenue

SETTING SALARIES
How much should practice owners pay themselves?

THE GENDER PAY GAP
Why women docs earn less—and how to change that
less screen time.
more patient time.

You didn’t go into healthcare to spend more time with your computer than with your patients. Good thing our services and expert back-office teams are here to help. At athenahealth, we take on the administrative work at scale, improving the efficiency of medical practices big and small, while freeing up doctors and medical professionals to focus on higher-value work.
The old saying you get what you pay for is generally true—except in healthcare. In America, though healthcare costs continue to rise, outcomes have gotten worse. Many lay the blame on doctors. However, the real culprits appear to be the executives at the top.

Apparenty, the big money is not in providing medical care, but in overseeing those who do. Data show that while doctors’ pay has remained flat or declined in recent years, top executives at major health systems have enjoyed a considerable boost in compensation. And their ranks are multiplying.

According to one study published last fall, from 2005 to 2015, mean annual compensation for major nonprofit medical center CEOs increased 93 percent, from $1.6 million to $3.1 million.

During that same time, these CEOs went from making three times more than an orthopedic surgeon to making five times more, and from making seven times more than a pediatrician to making 12 times more. This study was not the first to show that hospital management compensation frequently exceeds that of most physicians.

While this is not a world in which the person with the most years of schooling wins, something is amiss when our nation’s most highly educated individuals make one seventh of someone with half the education. These top hospital executives make multiples more despite never having touched a patient, ordered a test, made an incision, or shouldered the responsibility—and liability—of signing a patient chart. If they work at a nonprofit, they don’t even have stock shares on the line. They just get large, steady paychecks. Of course, the salary figures don’t tell the whole story. Top executives often earn much of their compensation in non-salary forms.

Meanwhile, the average primary care physician earns somewhere in the neighborhood of $250,000 per year. As the pay gap between doctors and administrators has grown, the number of healthcare administrators has also increased. Between 1975 and 2010, the number of U.S. physicians grew 150 percent, in keeping with the nation’s population. Meanwhile, the number of healthcare administrators increased 3,200 percent. The cost of that administrative burden today accounts, conservatively, for 20 to 30 percent of our healthcare spending.

Now, if patients were consuming more healthcare services and getting better results, maybe we could justify some of this. However, our consumption of healthcare services has been stagnant for a decade. What’s more, despite spending about twice what other high-income nations do on healthcare, our life expectancy has declined for the first time in 100 years. Meanwhile, the cost of healthcare closes in on 20 percent of GDP and shows no signs of slowing.

The answer to getting more affordable care and better results does not lie in paying doctors less. It lies in paying administrators less, and having a lot fewer of them.

Marni Jameson Carey is the executive director of the Association of Independent Doctors.
The Physician Report

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Second opinion

Why doctors fire patients
Physicians can handle many unruly patients, but one particular form of “bad” patient crosses the line, writes C. Andrew Schroeder, MD.

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MedicalEconomics.com
Ease patients’ financial pain points through billing transparency

In 2017, Black Book’s “Revenue Cycle Management” report revealed that the average patient was expected to pay more than $6,200 a year for insurance deductibles and other out-of-pocket costs. That’s almost 30 percent higher than average consumer healthcare costs in 2015. It’s also a harbinger of the shift toward consumerism that the healthcare industry needs to embrace.

The report also noted that 82 percent of providers and 92 percent of hospitals struggled with traditional collection methods. Millions of dollars in unreconciled medical bills were left on the table. Rather than spending millions more paying third-party agencies to chase those payments, providers are closing the gap by changing their methods to cater to consumers.

That means more than providing excellent healthcare and service — it also means making everything, including admissions, billing, and coding, more transparent and convenient. When patients understand their out-of-pocket costs and the bills they receive are exactly what they expected, they’re more likely to pay them consistently and on time.

They’re also more likely to share their positive experiences online, which is the surest way for organizations to stand out from competitors. About 80 percent of internet users in a study by Pew Research Center’s Internet and American Life Project said they search for health information online. Among that group, 21 percent said they looked up reviews about particular doctors and hospitals before making a choice.

Appealing to consumers has traditionally been more of a retail strategy. Stores need consumers to choose them. In healthcare, patients’ choices have been restricted by limitations in their insurance, Medicare, or Medicaid coverage, which means organizations have had a largely predetermined supply of patients. As more costs for care and treatment shift to patients, they’re becoming more discerning about where they go to receive care. That is new territory for healthcare providers, which aren’t used to having to compete for business by appealing to savvy consumers.

“"If you are having a bad day, you can use acting to put your own personal feelings and behaviors to the side to show your caring, competent, and compassionate qualities. It’s not so much “faking it” as learning to embody the characteristics that create a good bedside manner.”
— Rebekah Bernard, MD, on how acting classes can help physicians learn to show empathy

“The most important thing that we can do to keep the momentum going is to keep security on the forefront of leadership’s minds. Leadership should include everyone from c-suite to board, from maintenance to caregivers, because all of them have a major stake in the security of the organization they work for, and the costs of ignoring the risks are catastrophic.”
— John Nye, on how to improve healthcare security

8 things physicians need to know about MACRA in 2019

The Medicare Quality Payment Program, enacted under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), will affect participating physicians’ payment in 2021.

To view, visit bit.ly/8-things-MACRA-2019

SEXUAL HEALTH

- Irregular periods could be a sign of more serious conditions
- Helping men choose a birth control option
- Open the dialogue around sexually transmitted infections (STIs)

For more, visit bit.ly/MEC-sexual-health

Medical Economics is part of the Modern Medicine Network, a Web-based portal for health professionals offering best-in-class content and tools in a rewarding and easy-to-use environment for knowledge-sharing among members of our community.
Give patients control of medical records

I read the March 10, 2019 cover article on Sharing Patient Data with great interest. As a practicing family physician with a well-functioning EHR I do not need and do not want access through a HIE to monster databases. What I and every primary care physician wants is simple. We need point of service access to the data that is clinically relevant for the patient in front of us, now, today.

There is a way to do that that by now should be obvious: put the records in the hands of the patient, and let that patient give access to their doctors!

Paul Buehrens, MD
KIRKLAND, WASH.

Solo physicians show their bravery

Melissa Young, MD, FACE, FACP in "Back to solo practice" (The Last Word, March 10) tells us the challenges she faces after her partner left their endocrinology practice.

I admire her courage to stay the course as a solo practitioner.

Going from seeing 8-12 patients a day to 24-28 patients a day represents a huge change. At the end of the day she must be exhausted from the emotional and physical strains. It would be interesting to know whether her partner simply retired or left to join a large group or a hospital network.

Edward Volpintesta, MD
BETHEL, CONN.

Thanks for the direct primary care articles

Kudos to Rob Lamberts, MD, for explaining direct primary care. This is truly a revolutionary movement removing insurance companies, government, and hospitals from the doctor patient relationship. Not only will it lower costs and increase both doctor and patient satisfaction, but it will stimulate more idealistic medical students to desire to enter primary care.

George B. Elvove, MD

“I admire her courage to stay the course as a solo practitioner.”

These days it is almost impossible to be a solo practitioner in most specialties and many physicians are leaving private practice to join large groups or hospital networks. The days of the solo practitioner are coming to an end.

Edward Volpintesta, MD
BETHEL, CONN.

Write for us! Medical Economics is looking for physician contributors to share their perspective with their peers on being a physician today, and can write compellingly about the challenges of practicing medicine. Interested in writing? Email us at medec@ubm.com to learn more!
Survey: Physicians uncertain if their children should study medicine

Primary care physicians are largely satisfied with their chosen career, but many hesitate recommending it for their own children. As part of the 90th annual Medical Economics Physician Report, we asked physicians questions about their decision to become doctors, and their hopes for the children.

Q: Would you recommend that your child or a friend’s child pursue a career in medicine? Yes: 42%, No: 23%, Not sure: 35%

Q: If you could go back in time and choose your career again, you would choose:
- The same specialty: 60%
- A different specialty: 24%
- A different career altogether: 16%

For exclusive survey data on physician salaries, malpractice rates and productivity, go to page 32.
Four ways to clean up your coding

1/ Incorrect billing by non-physician providers (NPPs)
In one practice we reviewed, the solo physician saw patients in the main office while the two NPPs saw patients in outlying offices. Yet, all NPP work was billed under the physician’s name. As a reminder, incident-to rules require that a physician be in the office when the NPP is seeing and billing patients “incident-to.” Otherwise, the care is billed under the NPP’s name.

In another, the NPP believed that because they spent more time with patients, they could routinely bill a level 4 visit. They thought that time was the determining factor in code selection. Yet, it was hard to believe that the minor clinical issues they treated (as demonstrated by the diagnosis codes chosen) required 40 minutes of “counseling.”

These are just two examples. In one practice, three years of mistakes like these added up to hundreds of thousands of dollars in take backs.

The bottom line: If you have PAs or NPs in your practice, engage an outside, independent entity to review the policies, procedures, and codes around the billing and reporting process.

2/ Hidden take backs
We’ve also uncovered physicians billing visits by time, but documenting incorrectly. Documentation for coding by time requires that both the face-to-face time and the amount of time spent counseling the patient are in the note. Our review revealed that in most cases, only one or the other (total time or counseling time) was documented.

Audits and take backs can go back several years. CMS, for example, will look back six years for incorrect reimbursements. So, just because you were paid last year doesn’t mean that money is yours to keep.

3/ Reliance on one code
When you see a pattern of using only 99202 for new patients and only 99214 for returning patients, it’s an indication that something might be amiss. Modern practices review their E/M coding patterns for each provider at least annually, and against the patterns of state and national data. This review identifies whether a provider’s pattern falls outside the “norms,” which could indicate incorrect or non-compliant coding.

Being an outlier isn’t necessarily wrong. Some specialists and subspecialties may have patterns that fall outside the norm. But significant variances arouse auditors’ curiosity, prompting them to take a closer look—especially when only two codes are used.

If you aren’t sure of how your providers’ patterns compare to peers, run a CPT frequency report and compare it to Medicare’s data in your specialty and state.

4/ Improper use of modifiers
In the majority of our audits, modifiers are being used incorrectly. Please see the box above for two common modifier mistakes.

Examples of incorrect modifier use

Modifier 25: Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. Routinely billing an E/M code with a 25 modifier for established patients receiving regular injections for the same diagnosis and anatomic site is just plain wrong. Our reviews have uncovered a high volume of these.

Modifier 59: Distinct, procedural service. We find frequent incidences of appending modifier 59 when it is not required, due to a National Correct Coding Initiative edit. Over-applying modifier 59 attracts payer attention, and that can lead to an audit.

Karen Zupko is president of Karen Zupko & Associates, Inc. in Chicago, Ill. Send your billing and coding questions to medec@ubm.com
What’s driving healthcare prices? Not doctors

by KEITH LORIA Contributing author

While some evidence suggests that rising physician prices drive growth in healthcare spending on the privately insured, a new study theorizes that increases in hospital prices, not physician prices, are causing healthcare costs to rise.

The study, published in the February, 2019 issue of Health Affairs, examines hospital and physician prices for inpatient and hospital-based outpatient services using actual negotiated prices paid by insurers.

"Prices for hospital-based services grew substantially over the time-period we studied with prices for inpatient services increasing by about 37 percent and prices for outpatient services growing by about 21 percent," says one of the study’s authors, Stuart V. Craig, a PhD candidate at the University of Pennsylvania’s Wharton School.

Typically, he explains, hospitals and physicians bill insurers separately for the services they provide. For example, the surgeon who performs a hip replacement gets a payment directly from the insurer, and the hospital gets a separate payment.

“We looked at the differential growth rates of these two components of price, the total price paid, and found that the payments to facilities grew much faster than those to physicians," Craig says. "This is especially important because facility payments are typically much larger than physician payments at baseline. Roughly 89% of total price growth came from increases in prices paid to hospitals rather than physicians.”

Therefore, Craig says, efforts to reduce healthcare costs should focus primarily on addressing rising hospital prices.

"The fact that hospital prices are larger than physician prices in the first place means that hospital price growth would be a bigger driver of spending growth, even if their growth rates were the same in percentage terms," he says. "But we find that there is a large difference in relative growth rates as well.”

For example, the researchers found that physician services costs associated with Cesarean sections increased by 5.9% between 2007 and 2014, while facility services costs associated with Cesarean sections increased by 41.9% during that period.

The cost of physician services associated with Cesarean sections increased at a rate slower than Consumer Price Index (CPI) inflation, while the cost of facility services increased at a rate faster than the CPI.

After accounting for inflation, the physician services component of a Cesarean got smaller, while the facility services cost of a Cesarean increased. Therefore, all of the true increase in cost came from increases in facility services costs.

Adam C. Powell, PhD, president of Payor+Provider Syndicate, a management advisory and operational consulting firm for the managed care and healthcare delivery industries, says the findings suggest that hospital prices are growing slower than those for hospitals, hospital prices are the result of negotiations between providers and insurers, and therefore reflect more than simply the underlying costs of providing care.
Policy

Healthcare prices

costs for a number of physician services, although increasing, have largely just kept up with inflation.

“The 2007-2014 era was a time during which there was a strong emphasis on reducing costs and increasing value in healthcare,” he says. “Physicians likely had less leverage when negotiating with insurance companies than did hospitals, due to the far less concentrated market for physician services than for hospital services.”

While physician prices are growing slower than those for hospitals, Craig says these prices are the result of negotiations between providers and insurers, and therefore reflect more than simply the underlying costs of providing care. In particular, the relative bargaining leverage between providers and insurers are an important determinant of prices.

REASONS FOR PRICE GROWTH

Theresa Hush, MPA, CEO of Roji Health Intelligence, a Chicago-based healthcare strategy firm, says hospitals have been able to negotiate higher rates with insurance companies, impacting the numbers the study found.

“Increased hospital pricing reflects the greater negotiating power that consolidated hospital systems now have with insurance companies,” she says. “Several studies of healthcare consolidation show that larger systems, rather than creating economies of scale, have driven costs up. Consolidation has increased investments in electronic records and medical technology, the acquisition of physician practices, and higher administrative costs.”

And when consolidated systems have greater geographical breadth, insurers can’t easily walk away from negotiations because of demands for higher reimbursements.

Powell says it’s not surprising that hospital prices grew faster than physician prices, as hospitals often have far more bargaining power. “There are many regions where hospitals are relatively scarce, and insurers must decide between contracting with them or limiting access to care,” he says. “Meanwhile, there are often multiple physicians providing services related to particular specialties in a given region.”

Additionally, physicians and physician groups may have affiliations with one or more hospitals. As a result, insurers may be able to provide an adequate network while being more selective in their physician contracting. Thus, hospitals have more bargaining power than physicians.

David Belk, MD, an internist in Alameda, Calif., notes that a major hospital might see several thousand outpatients and hospitalize a few hundred people each week, while contracting with at least a couple dozen insurance providers, each of whom pays a different rate for the thousands of separate outpatient and inpatient services that hospital provides.

“Rather than trying to keep track of each individual payment, hospitals simply grossly inflate all bills and take what they can get from each insurance company,” Belk says. “Most doctor offices do exactly the same thing, just on a smaller scale. Since the payments to individual physicians are less chaotic than they are to hospitals, doctors aren’t pressured to over-bill by nearly as much.”

Christopher K. Lee, MPH, CPHQ, clinical solutions manager for Family Health Centers of San Diego, says a major reason physicians are impacting prices less is managed care penetration.

“Under fee-for-service, physicians were paid for every service rendered. This incentivizes unnecessary, wasteful, and inappropriate care,” he says. “Under managed care arrangements, physicians are paid a capitation rate—that is, a per member per month fee—regardless of the number of patients seen or services provided in a given month. They are motivated, therefore, to only perform necessary services.”

ARE SWEEPING CHANGES NEEDED?

Kyle Varner, MD, an internist in Toppenish, Wash., says hospital expenses are growing at an out-of-control rate because almost every U.S. hospital has a local monopoly.

“In 35 states, it is essentially illegal to build new hospitals, and in the remainder of the states a mountain of regulation makes it nearly impossible even though it may technically be legal,” he says. “This means hospitals have all the power, and consumers have none.”

“Hospitals have all the power, and consumers have none.”

—KYLE VARNER, MD, INTERNIST, TOPPENISH, WASH.

8 MEDICAL ECONOMICS APRIL 25, 2019 MedicalEconomics.com
Why you should provide virtual patient care

For medical practices to remain competitive, grow revenue and maintain established relationships with their patients, it is imperative physicians incorporate telemedicine services into their practices and provide patients with the option for treatment through virtual care.

Here are five reasons why integrating telemedicine into a medical practice benefits both physicians and their patients:

**Increases patient satisfaction.**
It has been proven that patients are far more likely to be satisfied with a virtual appointment when it is administered with a doctor they know and trust. According to Kaiser Permanente, 93 percent of patients who use telemedicine to meet with their personal doctor have a positive experience that meets their healthcare needs. By offering telemedicine services in addition to in-office care, patients are more satisfied and more likely to remain loyal to their doctor.

**Improves patient outcomes.**
Work, conflicting commitments and personal schedules inhibit many patients from seeking care through traditional in-office visits, especially for needs such as follow-ups, to review lab results or discuss how a new medication is working out. Telemedicine makes it easy and convenient for patients to stay engaged with their treatment plan and receive a stronger clinical outcome.

**Increase practice revenue.**
Seeing more patients goes hand-in-hand with increasing revenue. By offering telemedicine, physicians can be reimbursed for a number of interactions that do not actually need to have a patient present in-person. A practices’ telemedicine provider should equip them with the tools and information needed to help them understand how to bill for telemedicine, how to follow telemedicine policies by state and how reimbursement guidelines differ for Medicare, Medicaid and private payers. In all, doctors can add up to tens of thousands of dollars per year in new revenue with just a limited number of virtual care visits per month.

**Allows doctors to see more patients without adding hours.**
When hospitals and private practices extend their patient capacity with virtual visits, they are able to see more patients. According to FPM, physicians typically work 50.7 hours a week, with only 67 percent of the time directed to face-to-face patient care. The remaining 33 percent of their weekly hours are used to consult family and other physicians and for administrative tasks and other office responsibilities. Telemedicine allows for the doctor to combine these tasks, like contacting patients, families and other doctors, freeing up time to accommodate more virtual patient visits during normal work hours.

**Provides a convenient solution for more than just the patient.**
New technology is creating safer and more effective platforms for patients to comfortably and conveniently talk with their doctors on a personal device, such as a smartphone or computer. The video conference capability that comes with virtual care also allows for multiple people, including long-distance family members, caretakers and other doctors or specialists, to virtually join the appointment and collaborate on providing optimal care.

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Primary care doctors are beset by challenges. At the same time, through grit and dedication, they are finding way to succeed for their patients and their practices. This exclusive, annual report provides data from your peers about the state of physician’s today, and timely strategies you can use to run a more efficient practice and improve patient care.

by THE EDITORS

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The challenges to sustaining a successful medical practice are numerous—declining reimbursements, government regulations, and third-party interference, among others, all play a role. But even in the face of these obstacles, many practices continue to hold their own financially. When asked about the financial state of their practice as part of the Medical Economics 2019 Physician Report, 22 percent of respondents said their practice is doing better than a year ago, 52 percent are doing about the same, and 26 percent are doing worse.

So what makes the difference between a booming practice and one stuck in neutral, or worse? The majority of physicians doing better than the previous year attributed their success to seeing more patients, enabling them to increase revenue. Yet many physicians work long hours already and wonder how seeing more patients or making other operational changes is even possible. 

As a starting point, physicians should figure out where their practice ranks compared to others of their size. "Look at the financials and benchmark them to get an idea whether you are performing as an average practice should," says David Zetter, CHCC, CHBC, senior healthcare consultant for Mechanicsburg, Pa.-based Zetter Healthcare and member of the National Society of Healthcare Business Consultants (NSHBC).

Look at the number of patients seen per day, the average reimbursement levels, and revenue per provider to figure out where the practice is lagging.

Once physicians know where to focus their efforts, financial improvements can often be generated by increasing staffing, improving productivity, embracing value-based care, or renegotiating payer contracts.
ADD STAFF TO INCREASE PATIENT CAPACITY

Adding staff can increase patient capacity. And while it means higher operating costs, in many cases, the extra help pays for itself in multiple ways. Sterling Ransone, MD, FAAFP, a family physician in Deltaville, Va., had reached a point where he couldn’t see any more patients in a day. When he couldn’t find another physician willing to relocate to the area, he opted to hire a nurse practitioner instead. Now, he is able to focus on more of the chronically ill patients who require complex care.

“For us, it was mainly about capacity, because when we didn’t have [a nurse practitioner], we were super busy,” says Ransone, whose wife is also a physician in the practice. “Part of the benefit to me is knowing that patients get to see someone and that I’ll be involved in the mix for their care. It’s been well worth it to my personal bottom line.”

This includes the benefit of having more time with his family during non-business hours. “In the early years, I took calls 24/7,” he says. “Once we started hiring midlevels, they could take some of the calls for us, freeing us to travel with our kids or be places the phone doesn’t reach.”

Similarly, Marc Price, DO, a primary care physician practicing in Malta, N.Y., found that whenever he took time away from the office, he was losing money because there was no patient revenue being generated. Adding a non-physician provider has helped with office efficiency and finances, even though those weren’t the only reasons he made the hire.

“I hired one not specifically for revenue, but more for lifestyle and service to patients,”

FINANCIAL STATE OF PROGRESS (compared to five years ago)

Better than five years ago • 31%
About the same • 34%
Worse than 5 years ago • 35%

WHY FINANCES IMPROVED OR WORSENED IN 2018

Top reasons for improvement
1. Seeing more patients
2. Change in practice model
3. Receiving pay-for-performance incentives
4. Renegotiated payer contracts
5. Addition of ancillary services

Top reasons things got worse
1. More time spent on uncompensated tasks
2. Higher overhead
3. Lower reimbursement from commercial payers
4. Greater technology costs
5. Government regulations
6. Difficulty collecting from patients
7. Penalties from quality metrics/pay-for-performance initiatives

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“Doctors that feel they are victims of the system or of payers are often the ones struggling. Those with more optimistic views on how to make changes based on the reality of the landscape are the ones that tend to be more successful.”

— PAM BALLOU-NELSON, RN, PH.D, PRINCIPAL CONSULTANT, MGMA

says Price. “When it comes to income, they make more than what you pay them.”

Price says the physician assistant helps him keep up with patient messaging, prescription refills, lab reports, and other administrative duties, freeing up more of his time to spend with patients.

Another staff addition that can pay for itself is a scribe. Ransone has been using one for 15 years, and says he went from averaging about 20 patients per day to 23-24, with between 22 and 23 being the break-even point on cost.

“The length of time required for any one patient was shortened and all the extraneous computer stuff was being done by someone else,” says Ransone. “I could get in more patients and wasn’t spending all my time following up on referrals and other administrative tasks. It’s been as good for my patients as it has been for my sanity.”

Larry Brooks, AIA, principal of Practice Flow Solutions in Roswell, Ga., and member of NSHBC, says that patients want an efficient visit, and a scribe helps accomplish that not only in reduced wait times, but also in patient satisfaction.

“Using a scribe, a doctor can spend eight to 10 minutes with eye contact,” says Brooks. “A patient feels a lot better about that than a 15-minute visit with the doctor looking at a computer one-third of the time.”

When looking at staffing that can boost revenue, don’t forget about billing, says Zetter. “Not following up on denied claims or unpaid claims can be costly,” he says. “Revenue growth is about understanding the whole practice—can you add patient revenue, ancillary services, or something like chronic care management [CCM]? If you have a patient population that needs CCM, bringing in another staff member to handle the paperwork for that is a no-brainer to get that $40 a month per patient.”

**INCREASE PRODUCTIVITY**

Experts say there are often pockets of wasted time in a physician’s schedule or inefficiencies in how patients flow through the practice. Eliminating these means more patients can be seen during the workday.

A small practice using a receptionist to triage patients might not have time to check in patients if the phone lines are busy. Or maybe vendors or drug reps are tying up the time of the front desk staff, even to the point where the doctor is coming out to talk to them for a few minutes. That time isn’t accounted for in the schedule, so it quickly creates backlogs and reduces the number of patients that can be seen in an average day, says Zetter.

Brooks says doctors often spend their time on non-productive tasks, such as walking a patient out after an appointment or trying to figure out which patient is next in line to be seen. And if the office space is laid out poorly, the doctor can waste time walking between exam rooms.

“These are all small things, but if you are doing them 30 or 40 times a day, eliminating them might save enough time for another office visit,” says Brooks.

An optimal design for a practice with four exam rooms is two rooms across from each other, not four in a line. That cuts down the amount of time the doctor spends going from room to room. The layout should also
The top 9 issues facing primary care in 2018

1. Burden of paperwork/quality metrics
2. Inadequate reimbursement
3. Third-party interference (e.g., prior authorizations)
4. EHRs don’t work as well as they need to
5. Lower reimbursement for primary care compared to specialty care
6. Recruiting young physicians
7. Growth and competition of convenient care/retail clinics
8. Malpractice/need for tort reform
9. Patients getting health information online

“Not following up on denied claims or unpaid claims can be costly. Revenue growth is about understanding the whole practice.”

— DAVID ZETTER, CHCC, CHBC, SENIOR HEALTHCARE CONSULTANT, ZETTER HEALTHCARE, MECHANICSBURG, PA.

help patients navigate their way back to the front desk without the need for an escort, so the doctor can quickly move on to the next patient, says Brooks.

Poor scheduling can also contribute to practice inefficiency. Too many patients with chronic conditions scheduled together can create backlogs, while too many patients with simple problems can create gaps.

“There’s a fine line to getting the right type of patient mix at a rate that keeps the doctor busy,” says Brooks. “Make sure there are always one or two patients ready, not six or eight waiting an hour.”

INCREASE REVENUE WITH VALUE-BASED CONTRACTS

As Medicare and private payers continue to incentivize value-based care, experts say physicians need to understand how these contracts can benefit their practice. “If you have Medicare patients, you have the ability to gather information right now on some of the value-based principles and measures Medicare is looking at,” says Zetter.

Assemble the information and compare it to similar practices to evaluate practice performance. Then go to each payer and ask if they have any quality-based incentives appropriate for the practice.

When potential earnings have been determined, practices can make a return-on-investment calculation based on how much work is required to collect and report the data. “If it makes sense, go ahead and sign up, because you might be able to earn several thousand dollars a quarter, with no cost to sign up,” says Zetter.

Price’s practice takes part in the Medicare Shared Savings Program’s Comprehensive Primary Care Plus model, is a Level 3 Patient-Centered Medical Home (PCMH), and has one value-based contract with an insurer. “Don’t pass up value-based opportunities or think they are too daunting,” says Price. “Look at how you can do it with maximum efficiency and capture the rewards.”

Obtaining certification for PCMH status can be costly, but Price found a program from an insurer that would pay for the transformation of his practice. “They paid the fee and I reap the benefits,” he says.

Many risk-sharing contracts will require either adopting an Alternative Payment Model (APM) or becoming part of an Accountable Care Organization (ACO), says Pam Ballou-Nelson, RN, Ph.D, principal...
on Bruner, DO, a neuromusculoskeletal physician in Bloomfield Hills, Mich., grew his practice partly through using social media.

Bruner wanted to educate patients and other providers about the non-surgical sports medicine he offers. He had to go beyond just getting his name known, because most patients don’t understand what he does. He focused his Facebook, Twitter, and Instagram posts on what he believes in and what patients could expect to see during a visit. Content has included videos that illustrate how to properly perform yoga moves that help with back pain. He also shares relevant informational articles from other sources that reflect his values.

Bruner says that using social media successfully requires doctors to decide what kind of practice they want. “Who is the demographic you are looking to see and how are you going to reach them through social media?” For example, he says, Instagram is more popular with a younger audience, while older people are more likely to be on Facebook. “How can you use those channels to help you get you to where you want your practice to go?”

“I still feel that most people aren’t looking for physicians online, but once they do hear about you, they use your website and online content to validate what they are hearing,” says Bruner. He hasn’t had many patients say they found him as a direct result of any social media posts, but his awareness campaign has caught the attention of other physicians and resulted in referrals.

He’s also used LinkedIn to introduce himself to other physicians and set up lunch meetings to discuss how they could work together. While his practice is more specialized than most in the type of treatment he offers, he says primary care physicians could benefit by following a similar social media strategy.

“Most people know what a primary care physician is, but they probably don’t know everything about what they can do,” says Bruner. With more competition from urgent care centers and retail clinics, primary care physicians may need to put more effort into differentiating themselves from other care sources. “I’m surprised more physicians aren’t taking this approach with their practice,” he adds.
consultant with the Medical Group Management Association. She says researching any potential partners is vital.

“The way to lose money in a value-based contract is to join any group and not understand how they are structured or how they are making sure care management and coordination are done so they can share savings,” Ballou-Nelson says.

Practices must study patient data to understand how to succeed in value-based care, no matter the practice model. “If your EHR cannot produce data or registries and can’t produce outcome data, then you can’t improve what you are doing,” Ballou-Nelson points out. “If you are paid on controlling the risk of a population, you better know what the risk scores are and make sure those patients get into the office and do everything they need to do.”

NEGOTIATE BETTER PAYER CONTRACTS

Physicians who think they can’t negotiate better payer contracts are usually wrong, says Zetter, but it takes preparation. “Everybody can negotiate. Many people don’t because they don’t think they have any leverage,” he says.

Leverage starts with understanding the value the practice offers the payer. Ballou-Nelson says practices have to evaluate their patient data so they can tell a story about what they bring to the payer, pointing out how they excel in areas that the payer values.

“If you are not bringing value to the payer and understanding what the payer needs you to report on, you are of no value to the payer,” she says. “Look at payers’ report cards on you. If you are not doing a good job in the metrics that are important to them, there is no reason they would give you a better contract.”

Zetter suggests examining two years’ worth of claims data. In some cases, this will reveal that a practice isn’t executing the financial basics, leaving money uncollected through denied claims or services that were billed incorrectly. “Fix the internal stuff first,” he says. “There is no reason to negotiate with you if you are throwing money away.”

Patient satisfaction is becoming a bigger factor in how payers view physicians, and if a practice isn’t measuring that, they may be missing out on leverage with payers, Zetter says. “A practice needs to find out what they need to do better with patients and act on it,” he adds. “If you have high scores on surveys, payers love that.”

If physicians want to improve their practice finances and be successful, they also have to improve their attitude, says Ballou-Nelson. “Doctors that feel they are victims of the system or of payers are often the ones struggling,” she says. “Those with more optimistic views on how to make changes based on the reality of the landscape are the ones that tend to be more successful. I worked with a physician who was struggling and his attitude was, ‘It’s all a game.’ Well, if you don’t play the game, you are not going to get the money.”

MORE INSIDE

For exclusive physician salary, productivity and malpractice data, see the Physician Report on page 32.
Best practices in setting your own salary

by Ken Krizner  Contributing author

Physicians who own their own practices can enjoy a work-life environment that likely can’t be found if they were employed by a physician group or hospital system.

But the question of how much a physician practice owner should pay him or herself isn’t as easy to answer as it might seem. There are many factors that the owner must take into account, physicians and other experts say.

Physician practice owners have to understand they are business owners and revenue generators, says Kenneth T. Hertz, FACMPE, principal consultant for Medical Group Management Association (MGMA) Health Care Consulting Group. “As business owners, they have to step back and look at the practice from that point of view.”

Doctors prefer not to think of themselves as businesspeople first. “But it is often said, ‘no money, no mission,’” says Salvatore Volpe, MD, a practice owner in Staten Island, N.Y., and Medical Economics editorial advisory board member. “I’m trained as a physician, but I’ll go belly up if I don’t think like a businessman.”

Sometimes, thinking like a businessperson means taking a reduction in salary, paying themselves last or taking no salary at all for a period of time. There is the staff to think about; overhead costs, such as lease, utility and malpractice insurance payments; and investments in equipment needed to keep the practice up to date.

“There is no doubt that some practice owners resist the idea of paying themselves last,” Hertz points out. “The reality is that practice owners have to pay the staff first. Owners get paid last.”

Melissa E. Lucarelli, MD, FAAFP, a Medical Economics editorial advisory board member who runs a family practice in Randolph, Wis., agrees.

“I think of my employees’ salaries as being a fixed cost, comparable to the mortgage,” Lucarelli says. “There would never come a time when the mortgage isn’t paid. It’s the same with staff salaries. If I can’t afford to pay my staff, I have a problem.”

Once a practice is on sound financial footing, there are many variables, foreseen and unforeseen, that play a role in salary, says Jeffrey Kagan, MD, a majority owner of a two-physician practice in Newington, Conn., and Medical Economics editorial advisory board member.

“The lifestyle of physicians is a factor, as is the type of practice they want,” Kagan points out. “It also depends on how many patients owners want to see on a daily basis and how much time they want to spend with those patients.”

HIGHLIGHTS

Review regional salary and benchmarking data to determine a range to pay yourself. Groups such as the MGMA can provide this information.

Physician practice owners say paying staff is of the utmost importance, and many will forgo their own paycheck in lean times to ensure staff is paid.
PLAN AHEAD

To keep the other physicians in the group and staff happy and to be sure there is ample revenue to reinvest in the practice, owners should always have a salary plan, Kagan says.

In anticipation of the next year, Kagan says, his practice’s accountant creates a budget based on the revenue from the previous two years. Since salary is partially based on productivity, two years is taken into consideration so if Kagan or his partner don’t produce as much revenue as expected, the decrease in income is more gradual, he explains.

At the same time, the accountant tries to predict whether practice expenses will be higher or lower for the coming year. Kagan bases the amount of salary he will receive on this forecast.

“If we know we have a costly capital expense coming up, we add that to the calculation,” he says. “As we go through the year, we’ll give ourselves bonuses if there is extra money. If there’s not enough money, the partners miss a paycheck.”

Dave Gans, MSHA, FACMPE, senior fellow, industry affairs for MGMA, says physicians who own their own practices don’t receive salaries in the traditional sense. Instead, physicians take what is called a draw, the revenue that’s left after practice expenses are calculated. The owner takes a percentage of the excess revenue on a predetermined bi-weekly or other periodic basis.

Jeffrey M. Kagan, MD, internist Newington, Conn.

AVERAGE PRE-TAX INCOME COMPARISON FOR BOTH EMPLOYED PHYSICIANS AND PRACTICE OWNERS

2018 median pre-tax income = $225,000

<table>
<thead>
<tr>
<th>Year</th>
<th>Cardiology</th>
<th>OB/GYN</th>
<th>Internal medicine</th>
<th>Family medicine</th>
<th>Pediatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+$17,000</td>
<td>+$37,000</td>
<td>+$28,000</td>
<td>+$32,000</td>
<td>+$10,000</td>
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<tr>
<td>2017</td>
<td>+$32,000</td>
<td>+$37,000</td>
<td>+$28,000</td>
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<tr>
<td>2018</td>
<td>+$32,000</td>
<td>+$37,000</td>
<td>+$28,000</td>
<td>+$32,000</td>
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with occasional adjustments based on the practice’s financial statement.

The amount of the draw is based on the profits, not the percentage. The percentage is based on the number of shareholders or partners and whether the shareholders or partners have equal or unequal shares of the business. For example, if four doctors are equal partners, each will take one-fourth of the excess, if there are three partners, each will take one-third.

“You want to be able to pay salaries within the context of [the practice’s] market,” Gans says.

The owners’ draws are the same as a salary, and they can choose the timing for when to reconcile their periodic biweekly or monthly draws to the total profits. Most practices do this quarterly, so they can adjust their draw higher or lower to avoid a “December surprise.”

However, there is no reason why the owners couldn’t choose to wait until the end of the year and take the distribution as a single payment, Gans says. As to leaving the profits in the business, the legal organization determines whether this is possible.

Lucarelli, who has run her family prac-

“When a practice gets into a difficult financial situation … you start to discuss salary. That’s when the personal financial needs of the individual physician rise up to a high level and get in the way of having reasonable discussions of what compensation ought to be.”

— KENNETH T. HERTZ, FACMPE, PRINCIPAL CONSULTANT, MGMA

Startup costs have a bearing on salaries

Opening a practice is just like opening any other type of small business. There are capital expenditures – purchasing equipment, renting space, hiring staff, etc. – that will impact how long before the practice becomes profitable.

Typically, physicians won’t initially take a salary if they’re investing in a new practice, says Erik Doerr, CPA, partner and tax manager for Enestvedt & Christensen, LLP of Burnsville, Minnesota. They are allowed to loan the company funds to cover initial startup costs. As revenue increases and physicians see the need to continue to invest, they can continue to loan the business money if they don’t want to borrow it.

There are capital contributions and loans from investors or owners. In a single-owner operation, it’s easier to call it capital contributed to the business instead of a loan, Doerr says.

“We typically recommend that capitalization is done by utilizing a low stock purchase with one or more promissory notes,” he says. “When a profit is generated, those notes would be paid off. The cash can be taken out of the business as a repayment of those notes instead of a distribution or draw.”

New practices typically lose money for at least the first one to two years while they build a patient base and invest in operations, Doerr says.

During that time, practice owners have control over how much salary they can take. However, Doerr points out, practice owners are allowed to skip taking a salary where there is a reasonable basis for doing so.

“I normally recommend that owners avoid taking a high, regular salary until the business becomes profitable,” he says. “Taking a salary on day one when you’re not profitable does not make sense.”

“If a physician elects not to take a salary, they must ensure that they have adequate savings to fund the business, as well as their personal financial obligations,” Doerr adds.

There are many variables to consider for physicians contemplating their own practice. The first consideration should be to establish reasonable expectations. Then, create a vision and plan for how to proceed – “mapping out the road you want to travel,” says Kenneth T. Hertz, FACMPE, principal consultant for Medical Group Management Association (MGMA) Health Care Consulting Group.

“It can be tremendously rewarding [owning a practice],” Hertz stresses. “But it will be hard work. It absolutely can and will be rewarding if done properly. And the physician can build wealth.”
“I think of my employees’ salaries as being a fixed cost, comparable to the mortgage. There would never come a time when the mortgage isn’t paid. It’s the same with staff salaries. If I can’t afford to pay my staff, I have a problem.”

—MELISSA LUCARELLI, MD, FAMILY PHYSICIAN, RANDOLPH, WIS.
In Texas, a primary care physician working in a Denton County clinic discovered she was being paid $34,000 less per year than a male physician who performed the same duties. She questioned the matter and was later fired by administrators, who cited poor job performance.

The Equal Employment Opportunity Commission (EEOC) brought the doctor’s claim to federal court. In a resolution reached late in 2018, a judge ordered the county to pay the female doctor $115,000 in damages and to correct its compensation policies.

In spite of numerous equal-pay regulations and ongoing EEOC enforcement, female physicians are chronically underpaid compared to their male counterparts.

“For every specialty and every geography, there is a significant gap,” says Christopher Whaley, Ph.D., an adjunct assistant professor at the University of California, Berkeley School of Public Health, who has studied the gender pay gap.

CLEAR DATA

Medical Economics found in its survey of primary care physicians that female physicians reported a median annual income of $175,000, while male physicians reported an income of $275,000. In other words, the women surveyed earn 63 cents for every $1 that men earn. At the highest end of the pay scale, 10 percent of male respondents say they earn $500,000 or more compared with only 3 percent of female respondents.

These results are similar to other industry studies, including one conducted in 2017 by Doximity, a social network of medical professionals. In its study of more than 65,000 physicians, the organization discovered that industrywide, women earned 27.7 percent less than men. When examined by specialty, data provided to Medical Economics show women family medicine doctors earn $212,535 annually, or about 83 cents per $1 that their male counterparts earn.

Based on the dollar figures reported in the surveys, it’s clear the lost lifetime earnings for a female physician can add up to $1 million or more. Whaley, who was the lead author on the Doximity study, says it’s surprising that medicine—with its intensive education requirements and high standards applied uniformly to all professionals—would demonstrate such wide discrepancies in compensation between men and women.

“It’s not as if a woman in the study sample had inadequate training,” he says.

REASONS BEHIND THE GAP

The Equal Pay Act of 1963 was the first law making it illegal for employers to pay women less than men for doing the same job. Subsequent state and federal rules have aimed to reinforce pay equality, but the regulatory stick hasn’t been enough to level out earnings. Census Bureau data from 2016...
show America's working women are earning just 80 cents for every $1 that men earn.

Implicit bias is often to blame for the historic pattern of discrimination, experts say. For example, women are less likely to be perceived as family breadwinners or as loyal workers willing to put in long hours, says Theresa Rohr-Kirchgraber, MD, FACP, executive director of the Indiana University National Center of Excellence in Women’s Health and a chief physician executive at Eskenazi Health. Rohr-Kirchgraber has studied gender pay gaps for years.

She advises female physicians—many of whom are in fact the breadwinners in their households—to avoid talking about personal issues at work. If a woman declines a meeting invitation because of childcare concerns, for example, it’s in her own best interest to skip the explanation. Talking about outside demands can give the impression that professional duties aren’t a priority.

“It set us up to look as if we’re not as enthusiastic about our jobs,” Rohr-Kirchgraber says.

Yet she doesn’t believe men in medicine are deliberately acting with a gender bias, or worse, encouraging it to gain their own financial advantage. “There is plenty of work to go around,” she says. “Guys are just as confused as women as to why this is happening.”

**LACK OF TRANSPARENCY**

Another reason for pay gap’s persistence is that organizations often keep workers’ salaries and bonuses confidential. Without that data, women can’t quantify discrimination, making it extremely difficult to address.

Sharona Hoffman, JD, LLM, professor of law and bioethics at Case Western Reserve University School of Law in Cleveland, says women in medicine need to start asking questions and advocating for transparency. “It might seem impolite, but if women are serious about closing the pay gap, they need the data,” Hoffman says.

Ana María López, MD, FACP, president of the American College of Physicians (ACP), says even if an organization won’t reveal comparative compensation data, physicians have a responsibility to do their own research. Other factors determine pay, such as regional market differences, years of experience, or hours of clinical time in proportion to other professional duties. Such data can build a case for negotiating higher pay.

“At my first job as an assistant professor, I remember being told my starting salary,” López says. “I just said ‘thank you,’ and I had no idea that I could have done research and negotiated anything.”

She recommends that physicians explore data from the American Association of Medical Colleges to get a general idea of salary ranges. Additionally, academic medical centers tend to have some safeguards in place to ensure equal pay, so they can be a source of benchmark data, she says.

In May 2018, the American College of Physicians published a position statement in the *Annals of Internal Medicine* addressing equal pay. The statement supports a number of solutions, including increased transparency in compensation data, training to reduce implicit bias, and requirements that women be included on boards and committees.
"We need more inclusive decision-making bodies to come up with better solutions, including moving equity from a lofty goal to something that we practice," López says.

**LET'S TALK ABOUT PAYCHECKS**

Conversations about pay don't have to be confrontational. It makes sense during annual reviews or contract renewals for female physicians to ask whether the organization is at least aware of any gender pay gaps, Hoffman says.

"They might not tell you the truth, and they might squirm a little bit," she says. "But you have shown that you're sensitive to the issue."

Women who suspect gender discrimination can file a complaint with the EEOC, but it's difficult to prove without supporting data, according to Hoffman, who worked for the EEOC from 1992 to 1998 as a senior trial attorney.

"I don't remember a single case that was purely pay discrimination, and that's because it's very difficult to get that information," she says. "It's hard for an employee to show evidence that she is earning 'X' while her male counterpart is earning more."

If a female physician suspects unfair pay, she can speak directly with an EEOC investigator to determine whether an actionable case of discrimination has occurred. The commission has contact information on its website (https://www.eeoc.gov/).

"No 'proof' is required at this stage, although of course, the more supporting evidence she has, the better," James Ryan, spokesperson for EEOC, tells *Medical Economics* in an email.

**BILLING PLAYS A ROLE**

In medicine, compensation can be tied to how much revenue a physician brings into the practice. And revenue is a direct function of billing. For example, CPT code 99215 for established patients brings higher reimbursement than CPT 99213, and women might be less inclined to code at the higher level, according to Whaley.

Rohr-Kirchgraber agrees, and adds that pay gaps are further amplified when women are less assertive than men in their billing practices. "We might feel sorry for the patient and may be tempted to bill a bit lower," she says. "And we don't appreci-
Why doctors fire patients

he was a stressed out single mother of two trying to make it in Los Angeles. On Friday afternoons she would call asking for the sedative lorazepam, to treat her intermittent anxiety. By the end of her phone call my assistant was frazzled and begging me to send in an emergency prescription. My offer was always the same, “I don’t care if it’s Friday. She needs to come in. I will wait for her.” She rarely came. One Friday afternoon she brought my assistant to tears. The line had been crossed and I promptly discharged her from the practice.

I recently informally polled 30 physicians and asked them to list reasons why they had discharged patients from their practices. Their work settings were academic or private, urban or suburban. There was no limit to the number of reasons given. Only 1 doctor had never discharged a patient.

The main reason why physicians dismiss patients is abuse to the medical staff or doctor. This was by far the reason listed most, appearing 17 times, with noncompliance following in second place. It was often the type of noncompliance that could seriously harm a patient, such as not reporting to an emergency department for chest pain when directed there by a physician.

Interestingly, the third most popular reason was physician intuition. This generally came from more experienced physicians and specialists. The reason may seem too general, and even a way to hide prejudice. But on further questioning, this gestalt was often connected to another listed reason such as unrealistic expectations. The unifying factor was always the origin of the referral. Physicians have a lower threshold for discharging patients if they are connected to a referring doctor with a toxic practice or are related to a certain family or friend group.

The reasons cited after abuse, noncompliance, and intuition were all lower in number and included: verbalized lack of trust in the physician, demand for inappropriate treatment, missed appointments, and sexual harassment. The least common reasons were: unrealistic expectations, threatening negative social media reviews, and excessive phone calls or emails.

Reasons that never appeared: Complexity of medical problems or lack of diagnosis.

So it seems that physicians are up for the challenge as long as they or their staff do not suffer abuse.

It is perfectly legal for a physician to discharge a patient for any reason. Many states do not even require that the doctor give an explanation. The obligation to the patient is more of an ethical and moral duty. In my experience, the best way to discharge a patient is a phone call followed by a certified letter. If the phone call is not feasible, a letter will serve as notification and documentation. The letter should include the effective date, resources to find another physician, and instructions on how to obtain medical records.

There are certain exceptions to the legal discharge of a patient including violating a person’s civil rights by discriminating based on race, religion, or sexual orientation. Also, a physician may not withdraw during the treatment of an acute medical issue. For example, a doctor cannot stop caring for a patient during a hospital admission.

My best recommendation is to consult your malpractice carrier prior to discharging a patient and they can provide a wealth of advice and even letter templates. Finally, please do not forget that we will always remember the 0.01% of patients who give us trouble, but we still have the vast majority who are always a pleasure to care for.

C. Andrew Schroeder, MD, is an internist and pulmonologist practicing in Beverly Hills, Calif.
How one ACO reduced emergency department use

by AMY KENNEDY  Contributing author

William “Tom” Thompson, a family medicine physician in southwestern Indiana, doesn’t want his patients to visit the emergency department (ED) for conditions that he could easily treat in his practice—say, a urinary tract infection, acute stomach pain, or even complications of congestive heart failure.

“I can see a patient five days in a row and it would be cheaper than one day in an emergency room,” Thompson says.

Yet until 2017, Thompson—like many primary care providers—had few resources to track his patients’ utilization of services outside of his office, such as inappropriate ED visits. Nor did he have the time or tools to address unnecessary high-cost utilization with his patients.

Today, as a participating physician in Deaconess Care Integration, a Next Generation ACO covering 36,000 patients, Thompson and hundreds of other providers can now leverage patient information and improvement resources offered by the ACO. Owned by Deaconess Health System of Evansville, Indiana, an Evolent Health partner, the ACO’s 250 primary care physicians are spread across three states (Indiana, Kentucky, and Illinois) and six health systems and use a variety of electronic medical record systems.

Deaconess turned its gaze toward ED utilization because “the trend was very high and moving in the wrong direction compared to other ACOs and to other health systems in our region,” says Fred Walisch, MD, the ACO’s medical director.

The problem came down to two issues: patient education and access. Patients often didn’t know which ailments called for primary care, urgent care, or the ED. In addition, if they sought an appointment with their family physician, a slot might not be available soon enough.

THE CHALLENGE

Physician engagement is difficult in any setting. At Deaconess, strategies and solutions for engagement must be adaptable across a wide range of settings, from large clinics in downtown Evansville to small rural practices. The ACO’s 250 primary care physicians are spread across three states (Indiana, Kentucky, and Illinois) and six health systems and use a variety of electronic medical record systems.

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LET PHYSICIANS DRIVE THE CHANGE, THEN LET OTHERS HELP SHOULDER THE WORK

Deaconess’ physician-centered approach sought to combine providers’ wisdom with the infrastructure—tools, incentives, and analytics—needed to translate that knowledge into everyday practice.

To get physician buy-in, the ACO needed primary care providers to champion the change, but not to get bogged down...
in the details of implementation. It partnered with its Physician Advisory Council to identify seven changes to practice operations for improving ED utilization. Some were simple and straightforward, such as revising the after-hours voicemail greeting to help patients determine the best care setting. Others required more substantial change, such as identifying ways to accommodate same-day appointments, or adding appointment slots in the early morning, evening or weekend. The changes required the coordination of entire physician practices, particularly practice managers.

“One of the big drivers was not putting all of the burden on the physicians,” Wallisch says. “Alternate office hours and same-day appointments do involve physician scheduling, but they also involve the whole office.”

The primary care practices could decide how many of the seven interventions they wanted to adopt.

**PROVIDE TOOLS AND INCENTIVES FOR IMPLEMENTATION**

For each of the seven changes, Evolent Health, a company providing an integrated value-based care platform to the nation’s leading provider and payer organizations, created a toolkit to guide practices through the steps of implementing the change. The toolkits are highly detailed—for instance, providing a suggested script for the after-hours voice mail message. But they’re flexible enough for practices to adapt them to their own settings and circumstances.

Toolkits in hand, a population health manager would visit the practices to discuss the initiative, educate staff and help work through barriers.

“Our approach has been to try to understand what is going on in that office to begin with,” Wallisch says. “What are the work flows? What are the pain points? We spend a lot of time trying to get to know the offices. Every office is different.”

Amy Kennedy is a population health manager at Evolent Health.

**USE ACTIONABLE DATA AND APPEAL TO PROFESSIONALISM**

Throughout the project—and continuing to this day—physicians get performance reports that include data about their patients’ utilization of healthcare services, including the ED. It’s data that Thompson had never seen before.

“At our quarterly meetings they’re able to provide me with a detailed list of how sick our patients are, how many times they’ve been in the emergency room, how much money I’m spending in this practice,” he says. Equipped with this data for the first time, he has been able to have more discussions with patients about topics such as the best times to use the ED.

**THE RESULTS**

Participation in the project far exceeded the ACO’s goals. About 85% of the ACO’s primary care providers joined the program. And the majority of those who participated adopted five or more changes. “We were hoping for 200 to 300 different changes within the offices,” Wallisch says. “We ended up with 650.”

As adoption went up, ED utilization went down, by 13% among ACO members and 30% in the commercial patient population. “Every quarter we have seen a reduction in utilization of the emergency department by our ACO patients,” Wallisch says.

**Editor’s note:** This article was first published in our partner publication, Managed Healthcare Executive.
The dangers of online reviews

Lately, I have been contacted by several medical practices complaining about negative reviews and comments being posted on Google, Yelp, and other physician review sites. This is an ongoing frustration for physicians whose reputations can be greatly damaged by false reviews.

One concern with social media and online review sites is that they do not require verification of someone’s identity or even a valid email account. Another concern is the lack of confirmation that the poster is, in fact, a patient of the practice. Some sites allow you to self-verify, so anyone—from a competitor to disgruntled employee—can write a review. Unfortunately, some sites are also unresponsive to complaints of reviews that contain misinformation or false information.

I am currently representing a client in a case where it appears very likely that the posters are being paid by a competitor to post false negative reviews. We suspect this because:

- multiple negative reviews of the practice appear on the same date or close in time by different individual posters
- the posters’ names do not match any name in the practice’s records
- the posters describe events the practice has no record of or seem incredibly farfetched or unlikely to have occurred
- the same person negatively reviews multiple practice locations, in contrast to the fact that most patients only go to one location
- multiple reviews on the same date or close in time reference and misspell the doctor’s name in the same way
- the posters have never existed or posted before, or they appear to have only reviewed businesses in other states
- many or all the posters post positive reviews for the same competitor in the local area.

In this example, it may be possible to remove the postings. Most are posted on Google, and the company is usually receptive to complaints about false reviews, particularly negative ones. However, medical practices aren’t always so lucky.

In another case, a patient with a vendetta appears to be stalking a practice. The patient has posted hundreds of negative reviews almost daily basis for close to a year.

The reviews contain many allegations about the physician, the practice, and staff. It’s not difficult to deduce the same person has posted them. Because the practice knows who the patient is, the practice may be have additional legal recourse.

Physicians often feel personally attacked and helpless when such reviews occur. There are steps you can take. It’s best to seek legal advice to learn what your options are.

Remember: Even if reviews are penned by non-patients, unless the review contains lies or misstatements of fact, it can be very difficult to prove defamation. One-star reviews that say nothing about the practice can be even more challenging to remove. Worse, most sites are hesitant to take any action when only an opinion is being shared, even if the opinion and poster are completely fabricated.

Practices and physicians must be careful if they respond to postings, as identifying someone as a patient may introduce HIPAA issues. An invitation for posters to “Please call to the practice to discuss your patient experience” might be the safest course of action if you feel a response is necessary.

The good news is that positive reviews can quickly bury the negative ones. If you aren’t already encouraging satisfied patients to write reviews, consider putting up signs or adding that to any kind of follow-up communications.

Ericka L. Adler has practiced in the area of regulatory and transactional healthcare law for more than 20 years. Send your legal questions to medec@ubm.com
Better data, better outcomes
How communities are connecting physicians and social services to overcome patients’ social determinants of health

by DAVID RATHS contributing author

Lynda Bascelli, MD, chief medical officer of Project H.O.P.E. provides primary care services for the homeless population in one of the nation’s poorest cities, Camden, N.J. Her organization is working with the Camden Coalition Health Information Exchange (HIE) to share patient data with social service agencies and the county jail.

“Getting social service agencies to become more involved is very important, especially with an underserved population like ours,” Bascelli says. “We are trying to get their diabetes or hypertension under control, which is virtually an impossible task when someone is not housed. It is a ridiculous thing to be talking to them about when they are scrambling for basic shelter.”

Health systems are becoming increasingly aware that social determinants of health (SDH) can have as much impact on patients’ health as the type of care they receive from provider organizations. Therefore, population health improvement initiatives are relying on closer collaborations with the healthcare and human services sectors.

The focus on SDH also requires that data flows across sectors that aren’t accustomed to collaborating. Most physicians are familiar with HIE organizations, which share lab results and orders with hospitals and other providers.

But several regions of the country are independently expanding their efforts to create community information exchanges (CIE). These CIEs, some created with support from the Robert Wood Johnson Foundation, link data and facilitate online referrals among medical providers and social service agencies involved in housing, food services, transportation, and corrections.

For example, physicians using the Camden Coalition HIE can be notified when their patients receive care in the jail’s medical system. Most of these efforts are just getting underway in 2019, starting with federally qualified health centers (FQHCs) and Medicaid accountable care organizations (ACOs). After working through governance and patient consent issues, the founding organizations are now turning to how physicians will use the CIEs and what types of social determinant data physicians want to see.

Initially, the Camden Coalition started in 2010 to focus on helping social service agencies get access to some medical data. Once they had medical data flowing to social services, the next logical step was for clinicians to be more aware of social challenges their patients are facing.

“For the patients our care teams serve, their medical complexities are often related to their social needs,” says Christine McBride, program manager of Camden Coalition HIE. “We are documenting those connections to social service agencies in our HIE to make sure it is not just one social worker who knows the patient is experiencing homelessness, but also the nurse, the physician, and the community health worker.”
Perhaps the most ambitious efforts to create a more holistic view of patients are taking place in California. The state’s Medicaid program, Medi-Cal, is working with 25 counties to pilot an effort called Whole Person Care to coordinate health, behavioral health, and social services.

The counties are starting to share data and coordinate care for vulnerable Medi-Cal beneficiaries who have been identified as frequent users of multiple systems with persistently poor health outcomes. All counties are deploying relatively new technology platforms, usually from startup companies focused on this market, to allow previously siloed organizations to share data, create shared care plans, and evaluate the progress for both an individual and the population.

In Marin County, the Whole Person Care program is using a technology platform to provide physical and mental health data to social service agencies and deliver SDH data back to a clinic where nurses and care coordinators can review the information.

The program has intentionally not yet incorporated physicians, says Ken Shapiro, director of the county program. “We know how valuable physicians’ time is,” he explains. “We have a phased roll out. Case managers and social workers are already using the platform. We want to get critical mass of care coordination nurses to use the system, work out the bugs, and work up the chain to the physicians.”

Care teams that include healthcare providers and social workers can use the platform to message each other, says Shapiro, who describes it as similar to having a discussion on Slack, the cloud-based collaborative work platform. Participants can begin a conversation about a patient, and the rest of the care team can see it. If a particular provider is mentioned, she will get notifications sent directly to her inbox.

“It has been a game changer for social service providers and community clinics to have this awareness and connection to other providers across the continuum,” he says.

One example of the platform’s value is for patients who are homeless and have mental health disorders. Often, they are unable to send in the necessary paperwork to prevent their benefits from expiring.

“We have someone monitoring people on the platform and updating their case managers on where they are with benefit expiration and renewal,” Shapiro says. “That information is now shared securely for all clients who are managed through Whole Person Care. We can keep them from popping in and out of social services, which is a huge determinant of health.”

It’s important to keep patients enrolled, as people who lose housing or food benefits tend to have much poorer health outcomes. Early intervention can improve their health, which ultimately saves the healthcare system and taxpayers’ money.

In southern California, local nonprofit 2-1-1 San Diego has built a CIE with 53 network partners across all sectors. 2-1-1 San Diego is just starting to use the CIE to formalize referral pathways from smaller physician practices with the goal of also adding independent practices to the network. The CIE includes a social risk assessment tool and sends alerts for emergency services or if the client is in jail. It also facilitates connections across multiple agencies and providers.

2-1-1 San Diego started in 2010 and has built relationships with area healthcare providers that have physician organizations, including Rady’s Children Hospital and Sharp HealthCare, an integrated health system. “Now they are ready to take it to the next step and send data to the CIE,” says Camey Christenson, senior vice president at 2-1-1 San Diego.

She says the CIE has created a longitu-
dinal client database that gives clinicians a snapshot view of their clients’ records. So, when a physician is trying to see if her patient is homeless or food insecure, she can look in the client record and see an overall color-coded client risk assessment rating, which is determined by the different agencies that conduct domain-specific risk assessments. She can then click deeper and see the assessments, the EMS transport history, or jail booking history.

“The technology and build-out were the easy parts. It is re-engineering the business processes that is difficult,” Christenson says. “The social workers and health plan care managers already understand the value. We are trying to move even further into the clinical setting.”

INPUTTING SDH INTO THE EHR
An added twist on the CIE concept is to have safety net clinics gather SDH information from patients and input the data into their own EHRs. Oregon-based nonprofit OCHIN provides EHR support services for 450 community health clinics with more than 10,000 clinicians across the nation. It has built EHR tools and worked with member clinics to develop workflows for gathering SDH information.

“There is an increasing realization that these issues determine the patient’s capacity to get better and have good health, and the way to get that information is to ask,” says Scott Fields, MD, OCHIN’s chief medical officer.

The first thing OCHIN did was build and pilot a tool to gather the information. “We have learned it is not always easy to ask the questions, nor is it always easy to follow up on what we learned,” Fields says. The second step, he says, is for clinicians to learn about the area’s resources and develop a process for patient hand offs to close the loop. This allows clinics to see whether patients went to a food pantry and, if so, what sort of help they received.

Fields says that means asking the right questions. Then, it’s documenting the answers, developing a methodology to respond to any issues, and creating a communication network among partner organizations.

There is no question that clinicians want to know about and address social determinants since they are so critical to patients’ well-being, but Fields says there are still questions about clinicians’ capacity to do this in addition to what they are already doing.

It’s not easy, but Fields says healthcare providers must find a way to make it work. New payment reform initiatives will incentivize providers to create more community information exchanges.

The good news is that it’s possible—and it’s working. Back in New Jersey, the Camden Coalition Accountable Care Organization (ACO) brings together Camden-area hospitals, primary care and specialty providers, behavioral health providers, community organizations, and residents to coordinate care for local Medicaid beneficiaries.

“I see a lot of excitement around the idea of care planning with social service agencies,” McBride says.

One of the coalition’s goals is to make sure patients are seen by a primary care physician within seven days of hospital discharge. The coalition is already seeing positive results.

Camden Coalition HIE studied 1,531 hospital discharges from Jan. 1, 2014, to April 30, 2016. The coalition found post-discharge primary care appointments within 7 days increased from 19.3 to 39.2 percent, meaning appointments more than doubled as a result of the program. It also found there were fewer 30- and 90-day readmissions in comparison to patients who received no or less timely primary care follow-up.

“Knowing what to do after that primary care visit is where I have heard a lot of providers saying they wish they had better communications among all the ways a patient is served,” McBride says.

Editor’s note: This article was first published by our partner publication, Physicianspractice.com.
Backdoor Roth Contributions
Since they were created in 1997, Roth IRAs have been the darling of retirement savers due to their tax-free treatment of both growth and distributions. Roth IRAs’ income eligibility limits, however, disqualify most physicians from taking advantage of them. However, a backdoor Roth IRA provides a workaround. Using this method, you can make a non-deductible regular IRA contribution (non-deductible because of income limits)—and the following day convert those assets to a Roth IRA. This will allow tax-sheltered growth on those assets, plus no tax on withdrawals. With these benefits come several requirements. Among them: You must hold the Roth account for at least five years and be at least 59.5 before you can tap the earnings tax-free and penalty-free. The good news is that, unlike traditional IRAs, there are no mandatory withdrawals or required minimum distributions at age 70.5.

Trusts and Family Limited Partnerships
The value of complete peace of mind can’t be understated. Trusts provide the ability to shelter assets from creditors above and beyond tort reform’s protections. Family limited partnerships are an alternative to trusts that are favored by many physicians. Along with protecting assets, these partnerships are useful in estate planning, as they provide a discounted valuation of the assets contributed. These discounted valuations can be particularly beneficial for gifting strategies, effectively allowing you to contribute approximately $20,000 per beneficiary, rather than $15,000—without having to file a gift tax return.

Cash Balance Plans
Simply put, cash balance plans offer physicians the opportunity to take larger tax deductions and accelerate their retirement savings. Cash balance plans are actually a type of defined benefit plan, but instead of requiring complex calculations that provide vague projections of retirement benefits, cash balance plans are more predictable and easier to understand. These plans can be used by smaller practices, including sole proprietors, as long as the cash flow needed to cover the funding requirements remains fairly consistent each year. Combined with more commonly used 401(k) plans, the two together can allow for generous pre-tax contributions of $150,000-$250,000, resulting in significant tax savings. Executing these combined plan design will require third-party administration by a licensed actuary.

529 Savings Plans
For those of you with children, college savings plans are a great vehicle for saving money for their education. With the new tax law, they can also be used to pay for K-12 private school tuition (up to $10,000 per year). These accounts are funded with after-tax contributions, with no additional taxes on asset growth if used for educational expenses. The annual maximum contribution that can be made to a 529 without filing a gift tax return is the annual gift exclusion amount ($15,000 in 2018). But you can contribute five years’ worth of gifts at one time ($15,000 x 5= $75,000). Unused funds can also be transferred to your other children’s 529 accounts. Finally, although the assets you deposit into a 529 account aren’t included in your estate, they don’t leave your control for estate-planning purposes.

HSAs
Those enrolled in a high-deductible health plan can establish a health savings account (HSA), which permits annual tax-free contributions of $3,450 for individuals or $6,900 for families (with an additional $1,000 contribution for those age 55 or older)—with no taxes incurred when withdrawn for payment of qualified medical expenses. Most HSAs will allow account holders to invest their funds in excess of account minimums. Combined with more commonly used 401(k) plans, the two together can allow for generous pre-tax contributions of $150,000-$250,000, resulting in significant tax savings. Executing these combined plan design will require third-party administration by a licensed actuary.

Craig W. Eissler, MBA, CFP, is a wealth adviser with Halbert Hargrove based in Houston.
**Salary**

*How much do physicians earn?*

- **2018 average pre-tax income**
- **2018 median pre-tax income**

**Average income by...**

**PRIMARY CARE SPECIALTY**

- Cardiology
- OB/GYN
- Internal medicine
- Pediatrics
- Family medicine

**Salary Breakdown by Specialties**

- **Internal medicine**
  - 2018 average: $250,000
  - 2018 median: $225,000

- **Family medicine**
  - 2018 average: $225,000
  - 2018 median: $225,000

- **Pediatrics**
  - 2018 average: $233,000
  - 2018 median: $225,000

- **Cardiology**
  - 2018 average: $225,000
  - 2018 median: $225,000

- **OB/GYN**
  - 2018 average: $425,000
  - 2018 median: $425,000

- **Dermatology**
  - 2018 average: $425,000
  - 2018 median: $425,000

- **Urology**
  - 2018 average: $375,000
  - 2018 median: $375,000

**Medical Economics**

APRIL 25, 2019

MedicalEconomics.com
$74,000 The difference in pre-tax income between male and female physicians in 2018.

$13,000 The gap between what private practice physicians earn and physicians at hospital-owned practices earn.
Productivity

**Average Number of Patients Per Week**

Average number of patient visits for all physicians = 85

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>Hospital-owned practice</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>60</td>
<td>75</td>
</tr>
<tr>
<td>Hospital in-patient</td>
<td>52</td>
<td>78</td>
</tr>
<tr>
<td>More than 50 physicians</td>
<td>$283,000</td>
<td>$283,000</td>
</tr>
</tbody>
</table>

**Average Number of Patients Seen Per Week, Per Practice Ownership**

**Where Physicians SAW Patients**

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>67</td>
</tr>
<tr>
<td>Hospital</td>
<td>11</td>
</tr>
<tr>
<td>Senior residences/nursing homes</td>
<td>3</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>2</td>
</tr>
<tr>
<td>Patient homes</td>
<td>1</td>
</tr>
<tr>
<td>Other locations</td>
<td>1</td>
</tr>
</tbody>
</table>

Staffing

**Average Number of Professionals in a Practice, by Size, 2018**

<table>
<thead>
<tr>
<th></th>
<th>Solo practice</th>
<th>Two-physician practice</th>
<th>3-10 physician practice</th>
<th>11-50 physician practice</th>
<th>More than 50 physician practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical assistants</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Front-desk workers</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Nurse practitioners/physician assistants</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Billers/coders</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Schedulers</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Office managers/practice administrators</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>IT staff</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Social service/care coordinators</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
Malpractice rates

Median annual premiums by...

**SPECIALTY**

- Cardiology
- Internal medicine
- Family medicine

**GEOGRAPHIC REGION**

- Northeast
- West
- Midwest
- South

**YEARS IN PRACTICE**

- 11-20
- 21-30
- 6-10
- More than 30
- 5 or less

**PRACTICE SIZE**

- 26-50 physicians
- >50 physicians
- 3-10 physicians
- 2 physicians
- 11-25 physicians
- Solo
Prior authorizations

TIME SPENT WEEKLY ON PRIOR AUTHORIZATIONS IN 2018

<table>
<thead>
<tr>
<th>Time Spent</th>
<th>Physician</th>
<th>Practice staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 20 hours</td>
<td>1%</td>
<td>17%</td>
</tr>
<tr>
<td>16-20</td>
<td>1%</td>
<td>12%</td>
</tr>
<tr>
<td>11-15</td>
<td>7%</td>
<td>30%</td>
</tr>
<tr>
<td>Less than 11</td>
<td>67%</td>
<td>32%</td>
</tr>
<tr>
<td>0 hours</td>
<td>24%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Average number of hours per week for physicians: 4.6
Average number of hours per week for staff: 11.6

BIGGEST FRUSTRATION WITH PRIOR AUTHORIZATIONS

- Time spent on authorizations: 40%
- Feeling as though a payer is telling me how to do my job/what's best for my patients: 33%
- Reasons for denial: 10%
- Lack of clarity on what requires a prior authorization: 5%
- Managing the number of outstanding requests: 4%
- Other: 2%
- No frustration with prior authorizations: 6%

Ancillary services

PERCENTAGE OF REVENUE FOR PRIMARY CARE FROM ANCILLARY SERVICES IN 2018 (AVERAGE)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine</td>
<td>10%</td>
</tr>
<tr>
<td>Family medicine</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>23%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>12%</td>
</tr>
</tbody>
</table>

MOST POPULAR ANCILLARY SERVICES IN INTERNAL MEDICINE/FAMILY MEDICINE IN 2018

1. ECG
2. Spirometry
3. Nutritional counseling/weight loss
4. Radiology/imaging services
5. Implantable contraceptives
6. Holter monitoring
7. Bone densitometry
8. Stress tests
9. Pharmacy services
10. Cosmetic/aesthetic procedures
11. Pain management
12. Urodynamics
13. Addiction medicine
14. Sleep medicine

CHANGE IN MALPRACTICE PREMIUMS FOR 2018, COMPARED WITH 2017

- Increased: 12%
- Stays the same: 47%
- Decreased: 6%
- Don’t know: 33%
- No answer: 2%

CHANGE IN MALPRACTICE PREMIUMS COMPARED WITH FIVE YEARS AGO

- Increased: 23%
- Stays the same: 28%
- Decreased: 12%
- Don’t know: 35%
- No answer: 3%

CHANGE IN MALPRACTICE PREMIUMS FOR 2018, COMPARED WITH 2017

- Increased: 23%
- Stays the same: 28%
- Decreased: 12%
- Don’t know: 35%
- No answer: 3%
Secondary income

**TOP 10 SOURCES OF SECONDARY INCOME IN 2018**

1. Consulting
2. Expert witness
3. Medical administrator
4. Clinic work
5. Speaking
6. Teaching
7. Nursing home
8. Clinical trials/research
9. Hospice
10. Locum tenens assignments

**AMOUNT OF SECONDARY INCOME (AVERAGE) IN 2018**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine</td>
<td>$59,400</td>
</tr>
<tr>
<td>Family medicine</td>
<td>$61,700</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$48,000</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$31,100</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>$54,400</td>
</tr>
</tbody>
</table>

**26%** of physicians who earned secondary income in 2018 did so by providing consulting services.

**MORE INSIDE**

Do physicians want their children to become doctors? Find out on page 5.
Best advice ever given to you by a peer

Maria Young Chandler, MD, MBA  
Business of Medicine / Pediatrics  
Irvine, Calif.

“Treat your life as a business (Me, Inc.) and you’re the CEO.”

George G. Ellis, Jr., MD  
Internal Medicine  
Boardman, Ohio

“One of my professors once told me the day you stop learning is the day you hang up your stethoscope.”

Antonio Gamboa, MD, MBA  
Internal Medicine / Hospice and Palliative Care  
Austin, Texas

“Focus on your family, and don’t let your wife and kids ever feel like they don’t know you anymore.”

Jeffrey M. Kagan, MD  
Internal Medicine / Hospice  
Newington, Conn.

“The hospital is not your friend.”

Melissa E. Lucarelli MD, FAAFP  
Family Medicine  
Randolph, Wis.

“Always thank a patient for asking about your family or about your health, and always send a sympathy card when your patient dies.”

Joseph E. Scherger, MD  
Family Medicine  
La Quinta, Calif.

“Spoken words evaporate. Written words are eternal.”

Salvatore Volpe, MD  
Pediatrics/Internal Medicine / Pediatrics  
Staten Island, N.Y.

“Slow down.”

The board members that contribute expertise and analysis to help shape content of Medical Economics.
“Not following up on denied claims ... can be costly. Revenue growth is about understanding the whole practice.”

David Zetter, CHBC, Healthcare Consultant  

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Physicians often feel personally attacked and helpless when [negative] reviews occur.”

Ericka L. Adler, JD, Healthcare Attorney  

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$74,000

The average annual salary gap between male and female doctors  

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Advertising in Medical Economics has accelerated the growth of our program and business by putting me in contact with Health Care Professionals around the country who are the creators and innovators in their field. It has allowed me to help both my colleagues and their patients.
“If we can’t reduce patient wait time at least we can make it more entertaining for them.”

**Build a cybersecurity action plan**

A cyber attack can occur at your practice at any moment. Our coverage will provide expert advice on how to prepare and protect your practice from emerging cyber threats, and what your action plan should be in the event of a breach or hack.
IN PRACTICE: TREATMENT POW3R

The DHHS Guidelines recommend the use of a complete triple therapy consisting of a dual nucleoside reverse transcriptase inhibitor (NRTI) plus an integrase strand transfer inhibitor (INSTI) for treatment initiation in most people diagnosed with HIV-1. First recommended by the DHHS Guidelines in 2009, dual NRTI plus INSTI regimens are now strongly recommended due to demonstrated efficacy, favorable safety, and ease of use.

Advantages of dual NRTI + INSTI triple-therapy regimens

- Demonstrated durable virologic efficacy, favorable tolerability and toxicity profiles, and ease of use
- High barrier to resistance
- Recommended for use when rapid initiation of antiretroviral therapy (ART) is warranted

Considerations:

The Treatment

- Virologic efficacy
- Barrier to resistance
- Potential adverse effects
- Convenience (eg, pill size/burden, dosing frequency)
- Known or potential drug-drug interactions

The Patient

- Pretreatment viral load and CD4 count
- Baseline resistance
- Pregnancy or potential to become pregnant
- Comorbidities and coinfections
- Insurance coverage/access to medication
- Adherence potential today and over the course of the patient’s lifetime

For more information on the advantages of triple therapy, visit hivtreatmentpower.com.

References: