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Refusing Medicare patients a reality

In response to your article, "Medicare payment advisory board in Congress' crosshairs" (Sept. 10, 2017), I agree with your premise that Medicare through the Independent Payment Advisory Board (IPAB) should not cut back anymore on the fee schedule.

In your article, you worry that physicians may refuse to take Medicare patients. I can tell you that this is already happening. Medicare-only patients amount to 8% of my office visits.

In the mid 2000s, through Medicare's Sustained Growth Rate (SGR) formula, they were paying about 34% of the physician's usual and customary fee. Today, they pay about 29% of that fee. They cannot cut down any more.

I am in private practice as an internist in primary care. I employ 1.5 full-time equivalent employees. I see patients in my office who have private insurance, nursing home patients, disability examinations, I contract with LHI to see patients for the Army and Coast Guard and I am medical director of a local hospice.

In real dollars, I need to bring in about $130 per patient visit to stay open. I track metrics on everything. My average Medicare payment is $61.70 per patient per visit. As a result, I have eliminated Medicare-only patients. Rather, I see Medicare patients who have a supplement plan, or a Medicare replacement plan. This adds an additional $25 per visit. This is still not enough.

I have significant overhead: payroll, taxes, internet, telephone bills, electricity, medical supplies, computer technology, malpractice premiums, etc. Income has to exceed expenditures, otherwise, I close my doors and put my employees out of work.

Kevin P Rosteing, MD MSMI
GREEN BAY, WISCONSIN

Value-based care advice not enough

In response to "Fighting Back: Top tips for physicians to take on Value-based care" (August 10, 2017), I saw your article in *Medical Economics* and agree, we have to fight back. "value care" is a joke. Instead of putting the burden for cost savings on the lowest paid docs in the system (the PCPs), why are we not lowering what we reimburse procedures that drive up cost? I know we are the gatekeepers, but a dermatologist should not be making twice that of a PCP for half the effort.

The question is: How do we translate this into actual reform with the decision makers? Specialists are overpaid because we reimburse procedures too highly—mainly a consequence of the AMA controlling RVUs. How do we attack that?

Not sure if I can help other than writing letters to the editors of the local newspapers.

James Kurz, MD
CHAPEL HILL, NORTH CAROLINA

Time to disrupt telehealth 'middle men'

The recent article on telehealth shows that it is time for another disruption. Telehealth corporations take 50% of the pay in return for scheduling services and liability insurance coverage.

There is room for a new company on the Airbnb model with a reduced take of 10-15%, leaving more money in the doctor's pocket with reasonable compensation. It is time for physicians to quit being slaves to a system that focuses on patient metrics and data entry.

Telehealth will eventually surpass office visits with new devices like "med wand" that add real time vital signs with a stethoscope and otoscope with a virtual physical exam. There will always be a need for office visits, and in-person care as well as for face-to-face patients visits and education—but get prepared for a new frontier where physicians and practices can break the tether to large health systems or geography.

Perhaps national organizations in primary care could form a non-profit telehealth support for individual providers and offer scheduling and an electronic record and liability coverage to expand access to care at a reasonable cost.

So I take heart that telehealth will bring power back to patients and physicians and help us cut out the "middle men" who currently control healthcare. ◘

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