THE PHYSICIANS FOUNDATION
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Physicians Committed to a Better Health Care System for All Americans

Health Reform and the Decline of Physician Private Practice

A White Paper Examining the Effects of The Patient Protection and Affordable Care Act On Physician Practices in the United States

Includes results of *Physicians and Health Reform,* a survey of 100,000 physicians

White Paper and survey conducted on behalf of The Physicians Foundation by Merritt Hawkins
Completed October, 2010

MERRITT HAWKINS
an AMN Healthcare company

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The Patient Protection and Affordable Care Act
On Physician Practices in the United States

Prepared by:

Merritt Hawkins
A Company of AMN Healthcare

Prepared on Behalf of

THE PHYSICIANS FOUNDATION
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The Physicians Foundation is devoted to advancing physician practices and improving healthcare quality for all Americans. More information about the Physicians Foundation can be found at www.physiciansfoundation.org.

PROJECT INITIATORS, PROJECT LEADERS, LEAD AUTHORS AND ADVISORY PANEL

Timothy Norbeck, *Project Initiator*
Timothy Norbeck is Executive Director of The Physicians Foundation, a not-for-profit grant making organization committed to improving the practice environment for physicians and patients. From 1977 to 2006, Mr. Norbeck served as the Executive Director of the Connecticut State Medical Society. Mr. Norbeck also served with the American Medical Association, the Rhode Island Medical Society and is past president of the American Association of Medical Society Executives.

Walker Ray, MD, *Project Initiator*
Walker Ray, MD, serves as Vice President of The Physicians Foundation, a not-for-profit grant making organization committed to improving the medical practice environment for physicians and patients. A practicing pediatrician for over 40 years, Dr. Ray served as president of the Medical Association of Georgia and also served as head of the Association's Legislative Counsel.

Mark Smith, *Project Leader*
Mr. Smith serves as President of Merritt Hawkins, the largest physician search and consulting firm in the United States. Merritt Hawkins is a company of AMN Healthcare, the largest healthcare staffing organization in the United States. Mr. Smith has over 20 years of experience working with Merritt Hawkins in the physician search and consulting field.

Travis Singleton, *Project Leader*
Mr. Singleton serves as Vice President of Marketing for Merritt Hawkins, the largest physician search firm in the United States. Merritt Hawkins is a company of AMN Healthcare, the largest healthcare staffing organization is the United States. Mr. Singleton has over 10 years of physician search and consulting experience working with Merritt Hawkins.

Phillip Miller, *Lead Author/Editor*
Mr. Miller serves as Vice President of Communications for Merritt Hawkins, the largest physician search and consulting firm in the United States. Merritt Hawkins is a company of AMN Healthcare, the largest healthcare staffing organization in the United States. Mr. Miller has over 20 years of experience in physician search and consulting working with Merritt Hawkins.

Terese Hudson Thrall, *Contributing Author*
Ms. Hudson Thrall is a healthcare editor, writer and researcher, and worked on the American Hospital Association's flagship publication, ***Hospitals & Health Networks,*** for 20 years, most recently as Senior Writer.

S. Wright Caughman, *MD, Advisory Panel*
S. Wright Caughman, MD, is Vice President for Clinical and Academic Integration in Emory University's Woodruff Health Sciences Center. He also is Director of The Emory Clinic and Executive Associate Dean for Clinical Affairs in the Emory University School of Medicine and former Chair of the Dermatology Department in Emory's School of Medicine.

Jane Jordan, *JD, Advisory Panel*
Jane Jordan serves as Deputy Counsel/Chief Health Counsel for Emory University with primary responsibility for healthcare related issues in all components of the Woodruff Health Sciences Center of Emory University as well as the clinics and hospitals of Emory Healthcare.

Richard Johnston, *MD, Advisory Panel*
Richard Johnston, MD, is president of the Medical Clinic of North Texas, a 150-member medical group located across the Dallas-Fort Worth Metroplex focusing on primary care with medical subspecialties. Dr. Johnston is Board Certified by the American Board of Internal Medicine.

Steven Levin, *Advisory Panel*
Steven Levin is a Managing Director with the Chartis Group, a healthcare consulting firm. He has 31 years of management consulting experience in the healthcare industry with specific expertise in strategic planning, organizational alignment, clinical program development, merger evaluation and business development.

Claire Pomeroy, *MD, MBA, Advisory Panel*
Claire Pomeroy, MD, MBA serves as Vice Chancellor for Human Health Sciences and Dean of the School of Medicine with UC Davis. She is an expert in infectious diseases and a professor of internal medicine and microbiology and immunology. Dr. Pomeroy oversees UC Davis Health System and all its academic, research and clinical programs.

Michael Rossi, *MD, Advisory Panel*
Dr. Michael Rossi, MD, is Executive Director of Lehigh Valley Physician Group, a 500+ employed physician group practice of Lehigh Valley Health Network in Allentown, Pennsylvania. He is the Walter and Hazel May Endowed Chair of Cardiology at Lehigh Valley Health Network, and a Clinical Professor of Medicine at Penn State University College of Medicine. Dr. Rossi is Board Certified by the American Board of Internal Medicine in both Internal Medicine and in Cardiovascular Disease.

David Spahlinger, *MD, Advisory Panel*
David Spahlinger, MD, serves as Senior Associate Dean for Clinical Affairs, Executive Medical Director of the Faculty Group Practice and Clinical Associate Professor of Internal Medicine with the University of Michigan Medical School. Dr. Spahlinger completed his residency training in Internal Medicine. In addition to maintaining patient care responsibilities, Dr. Spahlinger teaches clinical skills and supervises the medical students and residents who rotate on his service.

John D. Stobo, *MD, Advisory Panel*
John D. Stobo, MD, serves as Senior Vice President Health Sciences and Services for the University of California System. Dr. Stobo is responsible for system-wide coordination and communication among UC's health sciences schools and medical centers. He is responsible for policy development for UC's health system, and develops mechanisms for monitoring performance for the system's 16 health sciences schools and 10 hospitals on seven campuses.

John R. Thomas, *Advisory Panel*
Mr. Thomas is President and Chief Executive Officer of MedSynergies, which partners with healthcare organization and physicians to align their operations by providing comprehensive service solutions. Mr. Thomas has been with MedSynergies since its inception in 1996 and is a leading expert in healthcare finance, revenue cycle management and hospital-physician integration.

Ron Yee, *MD, MBA, Advisory Panel*
Ron Yee, MD, MBA is a Family Practitioner and serves as Associate Clinical Professor for the UCSF School of Medicine. Dr. Yee is the Chief Medical Officer of United Health Centers in Parlier, California, a seven-site Federally Qualified Health Center. In 2008, Dr. Yee was elected to the Executive Committee of the National Association of Community Health Centers (NACHC) and serves on the National Advisory Council for the National Health Services Corps.

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ABOUT THE PHYSICIANS FOUNDATION

The Physicians Foundation is a national, not-for-profit grant making organization dedicated to advancing the work of practicing physicians and to improving the quality of healthcare for all Americans. The Foundation is unique in its commitment to working with physicians nationwide to create a more efficient and equitable healthcare system. The Physicians Foundation pursues its mission through a variety of activities including grant making and research. Since 2005, the Foundation has awarded more than $22 million in multi-year grants.

The Physicians Foundation was founded in 2003 through settlement of a class-action law suit brought by physicians and state medical associations against private third-party payors. Its Board of Directors is comprised of physician and medical society leaders from around the country. Additional information about the Foundation may be accessed at **www.physiciansfoundation.org.**

Signatory Medical Societies of the Physicians Foundation include:

Alaska State Medical Association
California Medical Association
Connecticut State Medical Society
Denton County Medical Society (Texas)
El Paso County Medical Society (Colorado)
Florida Medical Association
Hawaii Medical Association
Louisiana Medical Association
Medical Association of Georgia
Medical Society of New Jersey
Medical Society of the State of New York
Nebraska Medical Association
New Hampshire Medical Society
North Carolina Medical Society
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ABOUT MERRITT HAWKINS

Merritt Hawkins is the largest physician search and consulting firm in the United States. As a company of AMN Healthcare (NYSE: AHS), Merritt Hawkins is part of the largest healthcare staffing organization in the country. Founded in 1987, Merritt Hawkins has conducted over 30,000 physician and allied health professional search assignments throughout the 50 states and has consulted with tens of thousands of physicians and healthcare administrators on multiple issues, including physician needs assessment, contract structuring, search strategies and execution.

Merritt Hawkins produces data that is widely referenced and utilized throughout the healthcare industry. Notable surveys conducted by Merritt Hawkins that have yielded national benchmark data include:

Survey of Patient Appointment Wait times

Survey of Physician Inpatient/Outpatient Revenue

Review of Physician and CRNA Recruiting Incentives

Medical Practice: The Physicians' Perspective
(conducted for The Physicians Foundation)

Survey of Primary Care Physicians
(conducted for Physicians Practice magazine)

Survey of Final Year Medical Residents

Executives with Merritt Hawkins have authored hundreds of articles and have written three books, including:

Will the Last Physician in America Please Turn Off the Lights?
A Look at America's Looming Doctor Shortage

Merritt Hawkins' Guide to Physician Recruiting

In Their Own Words: 12,000 Physicians Reveal Their Thoughts on Medical Practice In America
(written on behalf of The Physicians Foundation)

Merritt Hawkins' executives have addressed hundreds of healthcare organizations and speak nationwide on a variety of healthcare related topics. Additional information about Merritt Hawkins and AMN Healthcare can be accessed at **www.merritthawkins.com** and at **www.amnhealthcare.com.**

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ABOUT THE White Paper ADVISORY PANEL

The Patient Protection and Affordable Care Act (PPACA) and its potential effects on physician practice are wide ranging, fluid topics subject to a variety of interpretations and analyses.

In order to incorporate a broad perspective and to benefit from a multi-disciplinary source of expertise, Merritt Hawkins assembled an Advisory Panel to assist in providing strategic direction and overview of this White Paper.

The White Paper Advisory Panel includes experts with in-depth experience representing a number of different backgrounds, including academic medicine, healthcare administration, research, small and large private practice ownership and administration, as well as medical practice management consulting.

During a two-day meeting held in July, 2010, the Advisory Panel set the strategic direction for the White Paper and offered a variety of insights into the potential effects of health reform on physician practices. Panel members were able to review various sections of the White Paper as they were completed and review the final draft, as well as exchange comments on the White Paper through a dedicated online discussion room. Panel members agreed with certain broad propositions regarding healthcare reform outlined in this White Paper. However, consensus was not achieved on all the various aspects of reform examined herein and Panel members may hold views that diverge from some of those expressed in the White Paper. Panel members represented their own views and not necessarily those of the institutions with which they are affiliated.

The White Paper includes case histories of various practice structures likely to be prevalent in the post-reform era. Some of these case histories were drawn from practices or institutions represented by Panel members.

The Physicians Foundation would like to thank members of the Panel for the time, insight and expertise they contributed to this project.

EXECUTIVE SUMMARY

Like society itself, medical practice has been evolving rapidly in the United States over the last 50 years, in response to technological, economic, demographic, political and related influences. Passage of the Patient Protection and Affordable Care Act ("health reform") promises to accelerate this evolution in a variety of significant ways.

The Physicians Foundation called upon Merritt Hawkins and an Advisory Panel of healthcare experts to assess how health reform is likely to affect the ways in which physicians practice in the United States. This White Paper reflects the results of Merritt Hawkins' and the Advisory Panel's analysis.

Meeting over a period of two days, the Advisory Panel delineated some general themes and projections, concluding:

1) Health reform is comprised of two elements: "Informal reform," (i.e., societal and economic trends exerting pressure on the current healthcare system independent of the Patient Protection and Affordable Care Act), and "formal reform," (i.e., the provisions contained in the Act itself).

2) The current iteration of health reform, both formal and informal, will have a transformative effect on the healthcare system. This time, reform will not be a "false dawn" analogous to the health reform movement of the 1990s, but will usher in substantive and lasting changes.

3) The independent, private physician practice model will be largely, though not uniformly, replaced.

4) Most physicians will be compelled to consolidate with other practitioners, become hospital employees, or align with large hospitals and health systems for capital, administrative and technical resources.

5) Emerging practice models will vary by region—one size will not fit all. Large, Accountable Care Organizations (ACOs), private practice medical homes, large independent groups, large aligned groups, community health centers (CHCs), concierge practices, and small aligned groups will proliferate.

6) Reform will drastically increase physician legal compliance obligations and potential liability under federal fraud and abuse statutes. Enhanced funding for enforcement, additional latitude for "whistleblowers" and the suspension of the government's need to prove "intent" will create a compliance environment many physicians will find problematic.

7) Reform will exacerbate physician shortages, creating access issues for many patients. Primary care shortages and physician maldistribution will not be resolved. Physicians will need to redefine their roles and rethink delivery models in order to meet rising demand.

8) The imperative to care for more patients, to provide higher perceived quality, at less cost, with increased reporting and tracking demands, in an environment of high potential liability and problematic reimbursement, will put additional stress on physicians, particularly those in private practice. Some physicians will respond by opting out of private practice or by abandoning medicine altogether, contributing to the physician shortage.

9) The omission in reform of a "fix" to the Sustainable Growth Rate (SGR) formula and of liability reform will further disengage doctors from medicine and limit patient access. SGR is unlikely to be resolved by Congress and probably will be folded into new payment mechanisms sometime within the next five years.

10) Health reform was necessary and inevitable. The impetus of informal reform would likely have spurred many of the changes above, independent of formal reform. Net gains in coverage, quality and costs are to be hoped for, but the transition will be challenging to all physicians and onerous to many.

These and other conclusions are examined in more detail in this paper.

Physician Survey

The report includes results of a physician survey conducted by Merritt Hawkins on behalf of The Physicians Foundation. Some 2,400 physicians who responded to the survey indicated how they reacted to health reform and enumerated ways in which they may alter their practice plans in the next one to three years as reform is implemented.

Key findings of the survey include:

1) The majority of physicians responded unfavorably to passage of health reform.

2) The majority of physicians believe health reform will increase their patient loads while decreasing the financial viability of their practices.

3) The majority of physicians plan to alter their practices patterns in ways that will reduce patient access to their practices, by retiring, working part-time or taking other steps.

4) Physician practice styles will be increasingly less homogenous. The full-time, independent practitioner accepting third party payment will largely be supplanted by employed, part-time, locum tenens, and concierge practitioners.

Complete results of the survey are included in this paper.

The Physicians' Perspective

Health reform is a large, moving target with multiple working parts. This White Paper focuses on its potential effects on physician practices. It is intended as a resource that physicians can use to both consider the implications of health reform and to navigate through the post-reform practice environment.

In concert with The Physicians Foundation's mission, the White Paper also is intended as a forum for presenting the physicians' perspective to policy makers, the media and the general public. How physicians view the practice of medicine, and how they choose to practice, is of fundamental importance to the quality and access to medical care afforded to all Americans. The Physicians Foundation is committed to demonstrating the link between a robust, autonomous physician work force and patient access to the highest quality medical care.

The majority of physicians believe health reform will increase their patient loads while decreasing the financial viability of their practices.

Introduction: The Arc of Physician Practice

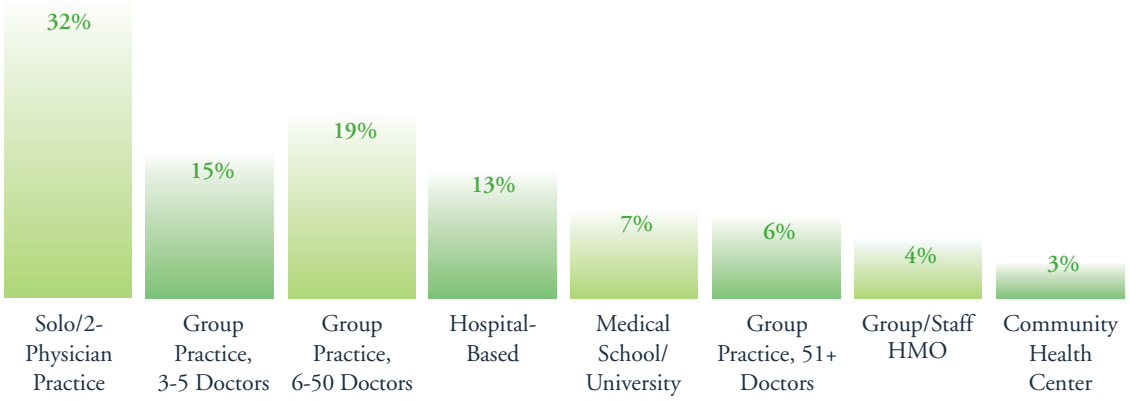
In medical practice as in life, change is the only constant. Society over the decades has progressed but at the same time has become increasingly complex–trends mirrored in medicine. Physicians today are able provide near-miraculous treatments to their patients as part of the most advanced healthcare system in the world. However, they also are mired in a practice environment that often is costly, contentious and increasingly unsustainable.

How will health reform affect the medical practice environment? What provisions of the new law will have the most direct impact on physician practices? What practice models are likely to be most prevalent in the post-reform era? How will reform affect demand for and access to physician services? What are the salient physician-related legal compliance issues implicit in health reform? What will be the role of organized medicine as the law is implemented? How do physicians themselves feel about passage of the health reform act, and what changes will they make in response to it?

Before addressing these questions it is important to put health reform in historical context. The impetus for health reform derives from the evolving interplay between physicians, patients, hospitals and insurers. These relationships have broken down and are at the point at which repair is indicated, hence reform.

Looking back over the last century shows how these relationships have changed. In 1900, a lone physician was likely to visit a patient in his home or in an office minimally outfitted with equipment, and be paid in cash for his services. Today, physicians negotiate with insurers—not the patient—for payment and are more likely to be part of a group practice with a brigade of support staff than to practice as soloists. In fact, small one-or two-doctor practices have become the minority (see chart below).[1]

U.S. PHYSICIANS BY PRACTICE TYPE



Source: Center for Studying Health System Change. 2008 Health Tracking Study Physician Survey. Sept. 2009.

As technology has proliferated, the number of physician specialties has increased, including some that were unknown a few decades ago, such as interventional radiology. In 1933, only 4 specialty examining boards existed, but today physicians can be certified in more than 145 specialties and subspecialties.[2] Technology also has created the demand for hospitals and physician practices to purchase expensive imaging equipment and surgical systems.

And as new treatments and diagnostic methods have multiplied, healthcare has become more costly, with the national bill reaching $2.5 trillion in 2009, amounting to 17.[3] percent of gross domestic product, about twice the percentage of other Western nations. In the United States, this percent was only 5.9 in 1965 and 10.2 in 1982.[3] Employers and consumers have been hit with cost increases yearly, with healthcare insurance premiums for employers doubling in the last decade.[4]

Doctors and Hospitals

Physicians and hospitals long have formed an arm's length alliance, with true integration often proving elusive. As the number of hospitals increased in the early 1900s, physicians began to practice in a "work shop" model, treating the hospital as an extension of their offices.[5] Because the doctors were the keepers of scientific knowledge and generated revenue for hospitals, they had a unique and paramount role. One example of this influence and autonomy is that the American College of Surgeons in 1918 adopted minimum standards for surgical environments, and hospital leaders followed them. As part of the requirements, hospitals were compelled to develop formal medical staff structures and medical staff policies to supervise hospital standards.[6]

Since that time, hospitals have shared the authority to provide care with physicians, with two separate domains: physicians overseeing clinical matters at the individual patient level and policing themselves through peer credentialing, while administrators oversaw hospital operations to meet needs at the community level. The hospital provided a place to treat patients, and the technology and support staffs to care for them and in return expected that physicians would serve in non-paid medical staff positions and hospital committees. All of these factors, perhaps, set the stage for difficulties in hospital-physician relations in later years.

The 1990s saw a wave of efforts to integrate hospitals with physicians, including joint ventures, physician-hospital organizations and physician practices purchases on the part of hospitals. The impetus for this movement was the belief that managed care—in which insurers negotiated with a limited panel of hospitals and physicians—would be the prevailing model of coverage. When demand for managed care ebbed in the late 1990s, many of these partnerships disbanded, in some case suffering from a lack of commitment from physicians and/or a lack of management expertise from hospitals.

While these previous moves to integrate were aimed largely at gaining bargaining power, recent attempts to align physicians and hospitals usually are initiated for the purpose of creating better quality metrics and more efficient operations with an eye toward participating in payer contracts that reward quality/efficiency performance. Healthcare reform encourages these alignments through pilot projects, such as those using bundled payments, and shared savings contracts with Accountable Care Organizations.

While many small physician practices have joined IPAs to negotiate with payers, it remains to be seen whether these same affiliations can serve to as a conduit to electronic medical records and quality initiatives. And it is still a question whether those physicians in one-and two-doctor practices will be able to align with other providers in a way that preserves their financial and clinical autonomy.

Payment Changes

With the rise of third party payers in the 1930s, physicians were paid by insurers, but their payments were kept separate from those of hospitals in Blue Cross/Blue Shield plans. This design was kept when Medicare, which began in 1965, developed its part A (hospital) and part B (physician) payments. In Medicare's early days, it followed the same approach as private insurance carriers, in which doctors were paid retrospectively for "usual, customary and reasonable charges," meaning they received essentially what they charged. The more services they provided, the more they could bill for, with no cost containment incentive and no consideration of quality. In the following years, use of public and private insurance increased—it accounted for only 25 percent of all personal healthcare spending in 1965, reaching 54 percent by 1982.[7]

But this type of payment could not continue. In 1982, actuaries announced the Medicare's Hospital Insurance Trust Fund would go bankrupt in five years. The following year, the Prospective Payment System (PPS) was implemented. Using diagnostic related groups (DRGs), the hospital's payment was fixed for a particular visit, no matter how many services were used. This put pressure on hospitals to contain costs and had the potential to cause conflict with physicians, as physicians might want more services and longer inpatient stays for their patients than the hospital thought was necessary to provide.

After the PPS program was put in place for hospitals, physician spending began to grow faster than hospital spending, and policymakers were already considering how to change Medicare physician payment. In 1992, a new rate-setting mechanism began to be used, called the Resource-Based Relative Value Scale (RBRVS). Basing payments on the resources necessary to provide the service instead of physician charges, it was intended to reduce price variations. However, because of concerns that the fee schedule would not adequately limit spending, the Sustainable Growth Rate (SGR) system has been used since 1998 to restrain aggregate spending. With SGR, spending on Medicare physician services is tracked to a spending target. If spending exceeds that target, physician payment updates are reduced. The first few years of the SGR use produced increases to the physician fee schedule, but since 2002 the updates resulted in a cut to physician rates. The SGR formula would have created a 23 percent cut in physician fees, but was forestalled by Congressional action delaying enactment of the SGR schedule until Nov. 30, 2010.[8] However, volume-based productivity remains a widely used method for compensating physicians. Merritt Hawkins reports in its 2010 Review of Physician Recruiting Incentives that productivity-based incentives, typically with a volume component, are offered to physicians in over 85 percent of its recruiting assignments.[9]

With purchasers of care demanding value, the next iteration of payment models for doctors and hospitals will likely be decided based on the outcome of some of CMS' and private payers' current pilot projects and innovations.

Advisory Panel members agreed that the nation's healthcare system cannot continue as it is and that, among other changes, volume-based payment for services will be reshaped or supplemented by value and quality-based metrics. While doctors and policy makers may doubt that the measures in the healthcare reform law will be able to reduce the costs of healthcare and provide more access to care, health reform—both formal and informal—is upon us and the arc of physician practice will bend.

The changes in the healthcare reform law are many and will be phased in over a period of years. While health reform faces legal and legislative challenges, two of the principles rooted in the law—that the uninsured should have health coverage and that clinicians and hospitals need to exhibit quality and efficiency value—are likely to stay at the forefront of healthcare policy.

In an effort to help physicians discover how they might adapt and thrive in this new paradigm, the White Paper examines how the healthcare law's provisions are likely to affect physician practices and presents case studies showcasing practice models likely to be prevalent in the era of health reform.

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The Patient Protection and Affordable Care Act (PPACA)

Provisions Affecting Physician Practice

The Patient Protection and Affordable Care Act and its corollary, the Health Care Education Affordability Reconciliation Act, are imposing pieces of legislation. It is beyond the scope of this White Paper to examine all their provisions and implications, the effects of which are likely to play out over a period of years.

Instead, the White Paper outlines those provisions that most directly affect physician practices and, more generally, provides examples of the types of physician practice models likely to be prevalent in the post reform era.

Among the many provisions of health reform are the following:

INSURANCE PROVISIONS

- U.S. citizens and legal residents must have health coverage. A tax penalty for lack of coverage will be phased in beginning in 2014. Exemptions will be granted for financial hardship.
- Employers with more than 50 workers must provide coverage or pay a penalty beginning in 2014.
- Medicaid will be expanded to non-Medicare eligible individuals up to 133 percent of the federal poverty level, with subsidies for persons earning between 133 to 400 percent of the poverty level.
- Create insurance exchanges in each state for small businesses and individuals to purchase coverage. Exchanges will offer plans in four benefit tiers, with varying levels of consumer coverage of the benefit costs, but all offering a baseline package of health benefits.

MEDICARE/PAYMENT PROVISIONS

- From 2011 to January, 2016, a 10 percent bonus on Medicare payments is available for primary care physicians. To be eligible, physicians must have Medicare charges for office, nursing facility and home visits comprise at least 60 percent of their total Medicare charges (more detail about this provision is provided in this paper in "Health Reform and the Physician Workforce").
- From 2011 to January, 2016, general surgeons performing major surgery in Health Professional Shortage Areas (HPSAs) are eligible for a 10 percent bonus payment.
- In 2011, incentive payments for physicians voluntarily participating in Medicare's Physician Quality Reporting Initiative (PQRI) will be increased by 1 percent for reporting in 2011 and by 0.5 percent for reporting from 2012 to 2014. An additional 0.5 percent incentive payment will be made to physicians who participate in a qualified Maintenance of Certification Program.
- Starting in 2015, physicians will be penalized 1.5 percent of Medicare payment if they do not successfully participate in the PQRI and in following years, will be penalized 2.0 percent of payment.

- Starting in 2015, a budget-neutral, value-based modifier will apply to Medicare payments for some physicians and physician groups. The modifier will aid in physicians obtaining reimbursement based on the cost and quality of care. In 2017, the modifier would apply to all physicians.
- The 2009 geographic payment adjustment (GPCI) floor is re-established in 2010. In 2010 and 2011, Medicare makes a separate adjustment for the practice expense portion of physician payments that will benefit physicians in rural and low-cost areas. Beginning in 2011, another adjustment will increase the GPCI adjustment for physicians in North Dakota, Montana, South Dakota, Utah and Wyoming. Physicians in 51 locations in 50 states, Puerto Rico and the Virgin Islands will benefit from the two practice expense adjustments.
- For 2010, Medicare will increase payment for psychotherapy services by 5 percent.
- Extends exception for Medicare per-beneficiaries annual limit on coverage of physical therapy, occupational therapy and speech pathology through 2010, providing a continued avenue for older patients to obtain therapy services.
- For 2013 and 2014, states must pay primary care physicians (family physicians, general internists, pediatricians) who provide Medicaid patients certain services (evaluations, management and immunizations) at a rate equal or greater to the current Medicare rate.
- Starting in 2010, Medicaid must cover tobacco cessation services for pregnant women. Also in 2010, private health plans must provide a minimum level of coverage without co-pays for certain preventive services.
- Starting in 2011, co-pays will be eliminated for Medicare and Medicaid enrollees who receive certain preventive services and providers will receive 100 percent of payment schedule rates.
- Starting in 2011, increased payments to outpatient hospitals and physician services in states with majority of counties that have a population density of less than 6 people per square mile.
- Starting in 2011, certified nurse mid-wives will have their Medicaid reimbursement raised from 65 percent to 100 percent of the payment made to ob/gyns.
- As of 2011, annual wellness visits will be covered by Medicare.
- In 2010, Medicare patients whose prescription expenses reach the Medicare Part D "doughnut hole" will receive at $250 rebate. Over the next ten years, the beneficiary co-insurance for this coverage gap will be reduced from 100 percent to 25 percent.

DEMONSTRATION/PILOT PROGRAM AND ADDITIONAL PROVISIONS

- Extends through 09/30/11 the current demonstration authority for current gain-sharing projects to evaluate financial relationships between hospitals and physicians.
- Physicians or eligible professionals who order durable medical equipment for home health services are required to be enrolled in Medicare as of 07/01/10.
- By 2011, CMS to develop a Physician Compare website containing information on physicians participating in the Physician Quality Reporting Initiative (PQRI) program. CMS is also required to implement a plan to make information on physician performance publicly available on the Web site by 2013. The site would be similar to the Hospital Compare Web site already in operation.

- By 2011, CMS to install a new requirement that allows any Medicare advantage beneficiary a 45-day window to dis-enroll, enter in Medicare fee-for-service and enroll in Medicare part D.
- By 2012, CMS to establish an Accountable Care Organization (ACO) shared savings program whereby providers would treat at least 5,000 patients, and keep some of the money if they provide care at less than the expected reimbursement amount.
- By 2012, establish the "Independence at Home" demonstration project to provide for care for high need Medicare beneficiaries with primary care services in their homes, allowing clinicians to share in any cost savings.
- Starting in 2013, CMS to establishes a national voluntary pilot program starting for 10 conditions to bundle payments for episodes of care delivered by disparate providers, such as hospitals, physicians, long term care and post acute providers.
- In order to be exempt from the Stark self-referral prohibition, physician-owned hospitals must have provider agreements in place by 12/31/10.
- In 2011, HHS will award $50 million in demonstration grants for a five-year period to states to develop, implement and evaluate alternatives to the current tort litigation system. These alternatives could include health courts and early offer programs.
- Between 2013 and 2016, rules will be implemented to standardize health insurance processing requirements. Physician practices should benefit from improved revenue cycles and saved time and money in tracking claims.
- Grants to states will be provided to test delivery models, including the medical home.

DIRECTION APPARENT, DETAILS PENDING

In reviewing these provisions of health reform, and in considering the impetus provided by the societal/economic forces it terms "informal reform," the Advisory Panel believes that the general direction to which medical practice is heading is apparent, though many of the details are anxiously awaited.

For example, three agencies created by health reform likely to wield influence on the way physicians practice and how they are paid are not yet in operation. These include:

- **Center for Medicare and Medicaid Innovation.** The Center will test payment and service delivery models to reduce program expenditures. Beginning in 2012, the Secretary of HHS must submit an annual report to Congress describing the models tested and the results.
- **Independent Medicare Advisory Board.** This 15-member board will make recommendations to Congress on lowering Medicare spending, tracking a projected growth target determined by CMS' chief actuary. If the projection exceeds the growth rate for that year, the board must submit a proposal containing spending cuts. HHS is required to implement such proposals unless Congress rejects them. The board is prohibited from making decisions that ration care, increase beneficiary premiums or eliminate benefits, making healthcare providers the most likely parties to receive cuts. The board's proposals begin September, 2014.

- **Patient-Centered Outcomes Research Institute.** The Institute will generate research on clinical effectiveness. The act states that the institute cannot issue practice guidelines, coverage, payment or policy recommendations. Four of the seven members on the institute's board must represent physicians. While CMS will not use the information for coverage decisions, some observers wonder if private payers will.

Another issue left conspicuously unresolved by health reform is Medicare's Sustainable Growth Rate (SGR) formula.

Without a Congressional delay, which was passed this fall extending SGR enactment to Dec. 1, 2010, SGR now would be delivering to physicians a 23 percent cut in Medicare payments. The American Medical Association favors repeal of SGR, to be replaced by a system that more closely tracks the Medicare Economic Index. In the first four years of SGR 1998 to 2001, updates did track or exceed the Medicare Economic Index. But every year since then, the actual expenditures on physician services exceeded the allowed spending target, leading to mandatory but perpetually delayed cuts to Medicare reimbursement.

Advisory Panel members and other observers project that there is no political will to amend SGR, as repeal would give up the cost savings it was put in place to maintain, increasing annual budgets. Non-physician providers are not anxious to lobby for change as they know money added to physician payment will likely be taken from them. Several Panel members believe that SGR will never be overtly repealed or amended but will be "rolled into" whatever predominant physician payment model emerges.

PRIVATE PRACTICE SUPPLANTED

What can be anticipated from health reform (informal and formal) is significantly expanded insurance coverage, increasing efforts to tie physician and hospital payments to quality and efficiency, and transparency for purchasers of care to make better decisions. For instance, the Department of Health and Human Services (HHS) is slated to create a web site showing quality metrics on physicians.

Myriad pilot programs and payment changes (some preceding passage of the reform bill) point toward quality as an emphasis, such as penalties for neglecting to report quality measures in the Physician Quality and Reporting Initiative and experiments in which providers can share in the savings they generate through more efficient care delivery, such as the shared savings for contracts with Accountable Care Organizations (ACOs).

It will be difficult for independent, private practice physicians to afford the upfront investment needed to move toward delivery models such as ACOs or medical homes (see "Medical Home Case Study" in this paper). Prior to health reform, many physicians have indicated that reimbursement cuts, regulatory burdens, revenue cycle challenges, malpractice costs and other factors have pushed their practices to the breaking point. This trend was explored in detail by The Physicians Foundation in its 2008 survey The Physicians Perspective: Medical Practice In 2008 in which 84 percent of 12,000 physician respondents indicated income in their practices was flat or decreasing and only six percent described the morale of physicians as positive. Because health reform did not address physician reimbursement cuts, private practice physicians will be challenged in their efforts to adopt emerging delivery models on their own.

In addition, health reform will add another layer of cost and complexity to physician practices through imposition of a significantly higher level of legal compliance responsibilities (see "Health Reform and Compliance" in this paper).

In the 2008 Physicians Foundation survey referenced above, 76 percent of physicians described their practices as either overextended or at full capacity. Health reform will add 32 million people to the ranks of the uninsured, considerably increasing demand for physician services (see "Health Reform and the Physician Workforce" in this paper). This will put additional strain on physician time and increase staffing and administrative costs of private practice doctors.

Health reform will therefore push physicians further in a direction where they are already heading – either out the door or away from the traditional, independently owned private practice model, which is becoming largely unsustainable, and toward a number of emerging practice models. These models will vary by region and market, and will include ACOs, medical homes, large medical groups, community health centers, and/or hospital employment. In each case, physicians will forfeit the independent model in return for capital, technical, administrative and staffing resources provided by a larger entity. A growing number of physicians, however, will go "back to the future," by directly contracting with patients in boutique or concierge practices.

Following are several case studies which illustrate operational and reimbursement structures found in these practice models. These case studies include:

1) A medical home case study examining a practice which has grown through consolidation and is operating as a medical home.
2) A concierge practice which is directly contracting with patients on a monthly fee basis.
3) A community health center which is tailoring its practice to the lifestyle preferences of today's physicians.
4) Two aligned physician groups preparing to act as accountable care organizations.
5) A rural group practice which has aligned with its local hospital.

health reform will add another layer of cost and complexity to physician practices through imposition of a significantly higher level of legal compliance responsibilities

Medical Home Case Study: Medical Clinic of North Texas

Although the medical home concept is not new, its proponents were glad to see the idea receive approval in the recent healthcare reform law. The law includes medical home demonstration projects for Medicare and Medicaid. The concept, in which a physician leads a team of clinicians in the delivery and coordination all of a patient's healthcare services, has shown that it can reduce costs, improve care and even decrease clinician burnout.[1] The medical home has been endorsed by four medical societies and propelled forward by the Patient-Centered Primary Care Collaborative, a coalition of large employers, insurers, consumer groups and doctors. In addition to federal medical home initiatives, a number of insurers have projects underway. For the Medical Clinic of North Texas (MCNT), a large multi-specialty group in the Dallas-Fort Worth area, this was a logical next step in improving patient care and one which a growing number of practices are expected to take post-reform.

But for Richard Johnston, MD, an Advisory Panel member, practicing internist and the president of MCNT, the journey to coordinated care started long before the clinic began working on the medical home model. To be able to track patient procedures and their outcomes, an electronic medical record is a key component—and that is one of the reasons Dr. Johnston's four-doctor practice made the decision to join MCNT in 2004. It is the type of move he thinks more and more small practices will make in response to healthcare reform and changing market conditions. Dr. Johnston noted that his colleagues at the four-doctor practice had concerns about its human resource policies, and HIPAA and OHSA compliance. In addition, the doctors were reluctant to invest in an electronic medical record. "We needed a higher level of management," he said. "We just couldn't stay on top of it." Since Dr. Johnston's group joined the clinic, MCNT has grown. In 2004, the clinic numbered 80 to 90 physicians and today it has nearly 150 doctors in nearly 50 locations, offering a raft of specialties. At MCNT, physicians are compensated based on productivity, with a small bonus distributed for patient outcomes, amounting to only 1 percent to 2 percent of salary. Dr. Johnston says this wasn't a transformative change for the four doctors from their previous compensation model.

The clinic has started medical home projects with insurers Cigna and Blue Cross Blue Shield of Texas, but the clinic's size was only one factor in the insurers' selection of MCNT. Dr. Johnston notes the fact that the clinic had an electronic medical record in place for many years, setting it apart in the Dallas-Fort Worth market. Both insurers had data showing MCNT to be a provider with high quality outcomes that delivered care efficiently.

Medical Home Pilot Projects

The projects appealed to the clinic's physicians because this model results in better patient care, said Dr. Johnston. "Unfortunately, it also costs money upfront," he added. To help with those costs, the insurers have paid for the clinic to hire embedded nurse coordinators to make sure a patient is getting appropriate care in the most efficient setting. The insurers also helped fund some of the clinic's IT initiatives, which in turn are producing data the insurers want to monitor. In both two-year contracts, the MCNT will continue to receive fee-for-service payments, creating stability for doctors. In addition, the clinic has the opportunity to keep a portion of the savings it generates. While other such pilot projects have generated savings[2], both MCNT projects—one started in late 2009 and another in January 2010—are too nascent to show their results. The Cigna project covers about 6,000 to 7,000 patients, while the Blue Cross contract includes care for 18,000 to 20,000 patients. Each contract involves all of MCNT's physicians, but the doctors treating adults have the most metrics to monitor and are likely to make the largest financial impact.

Dr. Johnston points out that the clinic already had in place a number of functions to facilitate the medical home projects. For instance, a search engine can go through a patient's medical record to identify tests or processes that are missing or late, and standing order sets prompt physicians to ask for particular procedures or tests when a patient presents with an abnormal lab result or a particular condition.

Dr. Johnston noted that if a practice is already functioning at a high level, such as hitting the standard for diabetes patients to receive a foot exam annually 80 percent of the time, it takes considerable effort to raise that to 90 percent. "A lot needs to be done before the doctor enters the exam room," says Dr. Johnston. "If the patient has a long list of concerns, you may never get around to that foot exam."

Dr. Johnston's practice, even before it joined MCNT, employed mid-level providers—one nurse practitioner and two physician assistants—so his practice's doctors were comfortable caring for patients with them. But to improve performance, non-physician clinicians need to be precise in their tasks.

To hit the 90th percentile for quality standards, said Dr. Johnston, "Every clinician has to be operating at the highest level of their license consistently." And that requires pervasive care coordination and extensive staff training. For instance, the certified medical assistants employed at MCNT receive an additional 12 weeks of training to perfect techniques in giving injections, how to use the clinic's electronic medical records, and learn more about disease processes in an effort to improve encounters with patients.

MCNT continues to work on building its capabilities. It is now trying to reach Level Three recognition of its medical home status from the National Committee for Quality Assurance. Practices must meet criteria to become a recognized medical home. To achieve the first level in the Physician Practice Connections—Patient-Centered Medical Home, a provider must achieve 25 to 49 points of 100 possible points in the following nine standards. To achieve Level 3, as MCNT is striving to do, the practice must reach at least 75 points in enactment of these standards.

NCQA Scoring Criteria[3]

STANDARD 1: ACCESS AND COMMUNICATION—9 POSSIBLE POINTS

A. Has written standards for patient access and patient communication*
4 possible points

B. Uses data to show it meets its standards for patient access and communication*
5 possible points

STANDARD 2: PATIENT TRACKING AND REGISTRY FUNCTIONS—21 POSSIBLE POINTS

A. Uses data system for basic patient information (mostly non-clinical data)
2 possible points

B. Has clinical data system with clinical data in searchable fields
3 possible points

C. Uses the clinical data system
3 possible points

D. Uses paper or electronic-based charting tools to organize clinical information*
6 possible points

E. Uses data to identify important diagnoses and conditions in practice*
4 possible points

F. Generates lists of patients and reminds patients and clinicians of services needed (population management)
3 possible points

STANDARD 3: CARE MANAGEMENT—20 POSSIBLE POINTS

A. Adoption and implementation of evidence-based guidelines for three chronic conditions*
3 possible points

B. Generates reminders about preventative services for clinicians
4 possible points

C. Uses non-physician staff to manage patient care
3 possible points

D. Conducts care management, including care plans, assessing progress, addressing barriers
5 possible points

E. Coordinates care/follow-up for patient who receive care in inpatient and outpatient facilities
5 possible points

STANDARD 4: PATIENT SELF-MANAGEMENT SUPPORT—6 POSSIBLE POINTS

A. Assess language preference and other communication barriers
2 possible points

B. Actively supports patient self-management*
4 possible points

STANDARD 5: ELECTRONIC PRESCRIBING—8 POSSIBLE POINTS

A. Uses electron system to write prescriptions
3 possible points

B. Has electronic prescription writer with safety checks
3 possible points

C. Has electronic prescription writer with cost checks
2 possible points

STANDARD 6: TEST TRACKING—13 POSSIBLE POINTS

A. Tracks tests and identifies abnormal results systematically*
7 possible points

B. Uses electronic system to order and retrieve tests and flag duplicate tests
6 possible points

STANDARD 7: REFERRAL TRACKING—4 POSSIBLE POINTS

A. Tracks referrals using paper-based or electronic system*
4 possible points

STANDARD 8: PERFORMANCE REPORTING AND IMPROVEMENT—15 POSSIBLE POINTS

A. Has written standards for patient access and patient communication*
3 possible points

B. Measures clinical and/or service performances by physician or across practice*
3 possible points

C. Survey of patients' care experience
3 possible points

D. Reports performance across the practice or by physician*
3 possible points

E. Sets goals and takes action to improve performance
3 possible points

F. Produces reports using standard measures
2 possible points

G. Transmits reports with standardized measure electronically to external entities
1 possible point

STANDARD 9: ADVANCED ELECTRONIC COMMUNICATIONS—4 POSSIBLE POINTS

A. Availability of Interactive Website
1 possible point

B. Electronic Patient Identification
2 possible points

C. Electronic Care Management Support
1 possible point

*Must pass elements

PPC-PCMH SCORING[4]

Level of Qualifying	Points	Must Pass Elements at 50 Percent Performance Level
Level 3	75-100	10 of 10
Level 2	50-74	10 of 10
Level 1	25-49	5 of 10

The difference between the medical home and the gate keepers of the 80s and 90s, stated Dr. Johnston, is that, in those earlier efforts, providers did not measure quality because they did not have the methods to do it. "How can you measure quality without electronic records?" asked Dr. Johnston, "The point is to prove outcomes; the dollars are predicated on that." He added that in MCNT's current medical home projects doctors are still paid fee for service and hence not financially penalized—unlike the earlier gatekeeper model—for ordering additional services for patients.

MCNT is only one of many practices that value the medical home model and believe investing in it is the key to the future. As of July 31, 2010, 892 practices have been recognized as by the NCQA as Patient-Centered Medical Homes since the program was launched in 2008. Also of as July 31, 2010, 508 applications were pending. The number of Patient-Centered Medical Homes will undoubtedly grow; the NCQA receives about 165 applications each month.[4]

Even though MCNT had a robust medical record before the medical home recognition project, it still had to make adjustments. For instance, the practice had no way to confirm if a patient had completed a suggested appointment with a specialist outside of the medical clinic, said Joanna Diehl, an MCNT project manager who has worked on the clinic's efforts to embrace the medical home model. The clinic had to create a way for the patient's electronic medical record to list the referral and to get the outside specialist to agree to send a report to the medical clinic about the outcome of that visit. "The clinic often didn't receive information about the referral visits, but the primary care physician is held accountable for that care," said Diehl. The clinic was able to work out an arrangement with specialists to send back reports of the visits, performed essentially in return for remaining in MCNT's referral network.

In the Dallas-Fort Worth market, insurers are not the only ones interested in the development of this model. The clinic has been approached by several self-insured employers interested in direct contracting. Before the clinic pursues these contracts, Dr. Johnston states, the employers need to complete more computations on how various co-pay levels would affect their plans' finances. For MCNT's part, the data generated from the medical home projects will provide more precise information for employers on the cost savings that the clinic can generate from care coordination.

To prepare for a direct contract that financially incents patients to choose MCNT physicians for care, the clinic needs to align primary physicians outside the clinic. Dr. Johnston said this is necessary in case patient demand becomes too great under the direct contracting arrangement. This alignment would be more complex than simply sending patients to outside physicians, he noted, as these doctors would have to follow MCNT protocols and be credentialed by the clinic.

Although MCNT has spent considerable effort coordinating care, the clinic has held back from aligning with a hospital. "In a fee-for-service market, the push to align is not strong," said Dr. Johnston. But the clinic's stance may change. "Aligning with a hospital or hospitals might be something we have to look at," noted Dr. Johnston. "I don't think global payments [for patient care] will happen anytime soon, but 'soon' used to be five-to-ten years and now it's two-to-three. The pace of change is picking up."

1. Reid, R., et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," Health Affairs. 2010; 29 (5): 835-843.
2. Milstein, A. and Gilbertson, E., "American Medical Home Runs," Health Affairs. 2009; 28 (5): 1317-36.
3. Patient-Centered Primary Care Collaborative. Proof in Practice A compilation of patient- centered medical home pilot and demonstration projects. 2009, pp. 89-90.
4. Ibid.
5. Information received from the National Committee for Quality Assurance, August 2010.

MCNT is only one of many practices that value the medical home model and believe investing in it is the key to the future.

Concierge/Direct Contracting Case Study: Qliance

As reimbursements decline, administrative time required for billing increases, and treatment pre-authorization remains a barrier to professional satisfaction, primary care physicians and even some specialists have found an alternative to traditional private practices: concierge-style practice. In these practices, physicians limit their panel of patients and charge them directly with a monthly fee. In exchange, patients can have more interaction with their doctors, such as unlimited and longer appointments, and access to physicians by phone and email.

A 2005 GAO study noted the growth of concierge practices between 2000 and 2004,[1] and some Advisory Panel members predict the trend—especially among older doctors—will continue into the future. The Survey of Physicians and Health Reform included in this White Paper indicates that 16% of physicians plan to switch to a concierge practice in the next one to three years. A number of firms stand ready to benefit from that possible trend, such as Concierge Choice Physicians and MDVIP. These firms help physicians determine whether their practices could successfully make the transition and they provide the support needed to become a concierge practice. The American Academy of Private Physicians, a professional organization of concierge and direct care providers, has a membership of about 500 and estimates the current number of concierge physicians at over 3,500.

Several models for concierge practice exist, including those that charge a monthly fee and also bill insurers for services, and those that split their practices between concierge and insurer-covered only patients, allowing patients to stay with a physician whether or not they choose the concierge model.[2] Others, like Qliance in Seattle, Washington, have bypassed insurers entirely, relying solely on monthly payments from patients.

While Qliance is a small practice, it is growing. Its nine doctors and three nurse practitioners currently care for nearly 4,000 patients at three locations in the Seattle, Washington area, and work with 80 employers who offer the service to their employees. Garrison Bliss, M.D., the internist who co-founded the practice in 2007 and serves as its president, plans to hire more clinicians and open two new locations by mid 2011. Dr. Bliss changed to the concierge-style practice in 1997, converting Seattle Medical Associates, believing the style improves both care for the patients and improves conditions for doctors. He later started Qliance in an effort to reduce monthly costs and create a model that could easily grow in scale. In the insured model, he noted, the net income per visit forces them to rush patient visits, which need to number 25 to 35 patients a day. All of this reduces the time available to diagnose and properly care for patients. "The insurer-based system has lots of incentives to see patients for five minutes, charge for it and be really good at billing," he said. At Qliance practices, doctors see 10 to 12 patients a day, with average visits lasting 30 to 60 minutes. Urgent care needs from patients receive same-day or next-day visits.

Qliance offers two levels of service. Level 1 offers office visits and remote hospital coordination with providers including nurse practitioners, internists or family practice doctors. A slightly more costly Level 2 offers only physician providers and, in addition to office visits, offers hospital rounding to coordinate care with hospitalists and specialists. At Qliance, a family pays a one-time $99 registration fee and then a monthly fee for each member of the family, based on age, not health

status. For instance, a teen's fee for Level 1 service is $54, while a 45-year-old would pay $69. For Level 2 service, those rates would be $54 for the teen, and $99 for the 45-year-old. Patients pay extra for such items as durable medical supplies, third party services and lab tests. Qliance recommends that patients use its services with a high deductible plan, or a health savings account, or both. These additional plans would cover major medical expenses such as hospitalizations.

Qliance doesn't include some of the benefits available at high-end concierge practices, such as house calls or providers that accompany patients to specialist appointments. Dr. Bliss pointed out that unlike some concierge models, he believes the costs to patients at Qliance make it affordable to 80 percent to 90 percent of Americans. Also, the practice doesn't exclude patients based on their health status or pre-existing conditions.

"Our objective is not to simply take care of wealthy people; they will always be able to afford health care," said Dr. Bliss. "The image of the concierge doctor taking care of the wealthy so they don't have to hang out with the unwashed masses doesn't fit here. In our practice, the venture capitalist sits in the same waiting room as the biker and no one has to sit very long."

Patients have reacted well to the model. "Patients who come here from traditional settings do experience a difference," Dr. Bliss stated. "They're seeing that primary care doesn't have to be on roller skates and that they can sit for 30 minutes with a physician and no one gets fidgety." The leadership at Qliance is now collaborating with insurers on how to develop high-deductable wrap around products to dovetail with its service model, which Dr. Bliss refers to as a Direct Primary Care Medical Home. Proponents of this model make a comparison to car insurance, pointing out that Americans don't use their auto insurance to pay for maintenance, such as having the transmission fluid changed and tires rotated.

But for the model to be affordable for patients, the costs have to be low, which Dr. Bliss said he's accomplished by bypassing insurers—and the overhead practices must carry to interact with them—from the equation. For instance, the practice uses a no-film digital x-ray service and negotiated a low fee for a local radiologist to read the images, costing patients $17 out-of-pocket for any set of films. Qliance also has a dispensary with generic medications that it sells to patients at cost. "Anything that is a significant cost, say more than $10," said Dr. Bliss, "We charge the patients at our cost and they pay cash."

This model may also get a boost from the insurance exchange feature in the healthcare reform law, which allows a direct practice medical home with a wrap around insurance product to substitute for any of the mandated insurance designs, as long as it provides the same coverage. In addition to his practice, Dr. Bliss has co-founded the Direct Primary Care Coalition, whose web site lists more than 60 Direct Primary Care Medical Home practices in 21 states.

BENEFITS OF DIRECT PRIMARY CARE MEDICAL HOMES

Half hour- to hour-long office visits
No limits for pre-existing conditions
No deductible or copayment to minimize barriers to usage
Same day or next day appointments for urgent care
Affordable, predictable monthly fees
All routine primary and preventive care including vaccinations, many lab tests, women's health service, on-site procedures such as such as suturing, casting, splinting, ongoing management of chronic diseases such as diabetes and hypertension
On-site X-ray laboratory and "first-fill" prescription medicine dispensary
Coordination of any needed specialist and hospital care and/or
Open seven days per week, often with extended hours, plus phone and email consultations and 24-hour phone access to a physician for urgent after-hours issues.

Source: Bliss, G. Get Ready for More Direct Primary Care Medical Homes:
Opening the Door to Insurance-Free Primary Care in State-Run Exchanges. Bureau of National Affairs' Health Care Policy Report. April 12, 2010.

Economic Model for Doctors

In a case study about Qliance he co-authored for Health Affairs, Dr. Bliss explained the finances behind the model that make it so attractive to physicians. At $60 per month, the annual revenue for each primacy care practice patient is $720, or 2.6 times higher than the average of $276 computed in 2008 by the Medical Group Management Association. MGMA figures show average annual revenue in 2008 of $621,338 per primary care physician, if the physician carries the average patient panel of 2,251. In the direct care model, a physician can generate the same annual revenue by seeing just 863 patients.[3]

Physicians at Qliance are paid on a salary, with bonuses amounting to 20 percent of their total compensation. Those bonuses are paid based on three indicators. First to be considered is the provider's panel size, with a full panel numbering 800 for a Level 1 provider and numbering 500 for a Level 2 provider, a doctor that is providing inpatient rounding. "We want providers to be at or near a full panel size," said Dr. Bliss. The last two criteria to determine bonuses are patient satisfaction and satisfactory benchmarks on quality measures. "The providers who are here know they are responsible for giving patients the care they need and making sure the patients are happy about their care," he stated. "If patients are happy they stay, and that will maintain a provider's panel size."

Quality and Cost

Dr. Bliss thinks this model has the ability to both improve quality and lower costs. For instance, if a patient has knee pain, Qliance providers could manage that symptom over the course of multiple office visits, and possibly avoid an MRI scan and a specialist referral. "In the insurer-based system, there's an incentive to do the scan because it's a way to get patients out of your office and get an answer quickly," said Dr. Bliss. "There's no way to turn one office visit into three because there is no time to spend with patients."

A Qliance analysis of downstream utilization costs showed that a sample of more than 2,000 patients under 65 had 54 percent fewer specialist referrals and used the emergency room 62 percent less over a one-year period compared to national benchmarks. One reason for these lower numbers, said Dr. Bliss, is that the practice is open nights and weekend hours. "One way to stop the use of unnecessary care is simply to be available," he said. But he also says the practice is still researching whether its patients tend to be healthier than the general population. Critics of concierge practices charge that they care for healthier patients, a charge Dr. Bliss denies, noting that two-thirds of his panel are Medicare patients, which often have more health concerns than younger individuals.

But if doctors are not at risk financially for the health of their patients, as the physicians at Qliance are not - are they incented to keep patients healthy? "The patients are the enforcers," he said. "They will not pay out of pocket for mediocre care. They will not keep coming back, and as a physician, you won't like your job very much if you are ineffective," stated Dr. Bliss. At Qliance, patients can drop the service at any time; they pay month-to-month.

Challenges and Solutions

Qliance has had its share of challenges. "It was a brand new machine," said Dr. Bliss, "and we had to evolve the manuals and invent the technology." For instance, the practice needed an EMR that included cash prices for lab tests, and Qliance had to create its own. In fact, the practice is still working on an EMR that will make a dash board available to clinicians showing quality measures, patient satisfaction and give them tools to manage care. For instance, Dr. Bliss would like physicians to be able to see all the patients in their panels who had taken hemoglobin A1c tests with scores that need follow-up. "We want to be able to generate a list of outliers and let our clinicians focus on those patients," stated Dr. Bliss. To create the EMR, Qliance has hired a highly qualified technical staff with the help of venture capital. Since 2006, Qliance has garnered $13.5 million in investments from such industry moguls as Amazon founder Jeff Bezos and Dell Computer's Michael Dell.[4] "We're taking advantage of being a venture capital driven organization," says Dr. Bliss. "I have no idea how a regular primary care practice is going to do this."

Other hurdles included the need to explain to Washington State regulators that the practice assumes no risk and shouldn't be regulated as an insurer. Qliance also has faced unrealistic patient expectations. "Sometimes patients wanted a prescription refill to be sent within an hour, and we didn't meet that time frame," stated Dr. Bliss.

While Dr. Bliss acknowledges that this model will take primary care physicians out of the supply pool as they limit their patient panels, he thinks it's a risk worth taking to make primary care more attractive, bringing both practicing physicians and medical residents back into the fold. "We could triple the number of primary care physicians if we paid adequately for primary care and corrected the incentive systems," he stated, adding that the doctors who choose primary care in graduating classes have sharply fallen, and that doctors in their 50s and 60s don't want to stay in the specialty.

"You have to increase supply and you can't do that if you just tweak the old system around the edges," he stated. "Whatever the short term downside of the model is, compared to the upside, it's a drop in the bucket."

1. GAO-05-929. Physician Services–Concierge Care Characteristics and Considerations for Medicare. August 2005.
2. Connor, M. Doctors Who Make House Calls. La Jolla Light. July 21, 2010. www.lajollalight.com/life/272160-doctors-who-make-house-calls
3. Wu, W., et al. A Direct Primary Care Medical Home: The Qliance Experience. Health Affairs. May 2010. 29 (5) 959-962.
4. Timmerman, L. Qliance Nails $6M from Bezos, Dell, Drew Carey for Primary Care that Avoids Insurance. Xconomy Seattle. April 27, 2010. www.xconomy.com/seattle/2010/04/27/qliance-nails-6m-from-bezos-dell-drew-carey-for-primary-care-that-avoids-insurance/

Physicians at Qliance are paid on a salary, with bonuses amounting to 20 percent of their total compensation.

Community Health Center Case Study: United Health Centers of San Joaquin Valley

Federally-qualified community health centers are a linchpin in the nation's healthcare delivery system, providing care in underserved areas—both rural and urban—and to those who are poor, uninsured and underinsured.[1] Their role will become even more important when 32 million Americans have coverage for healthcare. The chart below underscores the role community health centers play in providing care for the underserved.

COMMUNITY HEALTH CENTERS

	Health Center Population	US Population
% AT OR BELOW THE POVERTY LEVEL	53%	17%
% UNDER 20% OF THE POVERTY LEVEL	69%	32%
% UNINSURED	38%	15%
% MEDICAID	36%	14%
% MEDICARE	8%	12%
% RURAL	44%	16%

Source: National Association of Community Health Centers. United States: At A Glance. 2009.

Community health centers, numbering 1,250 with about 8,000 delivery sites, are already the largest network of safety net primary care services in the nation. These health centers will be strengthened over the next five years by $11 billion of additional funding allocated in the healthcare reform law. Of this amount $9.5 billion will go towards operations and patient services and $1.5 billion for construction and renovation. "Community health centers are at the heart of a modern, reformed healthcare system in America," said President Barack Obama during National Health Center Week in August, 2010. "We must continue to invest in these centers and ensure that comprehensive, culturally competent and quality primary healthcare services are accessible in every community across our nation."

According to estimates from the National Association of Community Health Centers (NACHC), this additional investment will allow health centers to double their current capacity, reaching 40 million patients in 2015. Also that year, the centers are estimated to generate $54 billion in total economic activity and create 284,000 new full-time equivalent jobs in their local communities.[2]

The funds for community health centers are part of a larger investment in primary care, including $1.5 billion in funding for the National Health Service Corps, with community health centers providing venues in which service corps members can work. In addition, funds to increase the number of primary care residency slots in community settings were included in healthcare reform, with the aim of training 500 additional primary care physicians by 2015.

In an environment in which physicians find themselves increasingly frustrated with administrative paper work, reimbursement issues, the demand to invest in information technology, and other challenges, practicing in one of the nation's federally funded community health centers is an option that might be attractive. While most health centers focus on primary care physicians—those specializing in family practice, pediatrics, internal medicine, obstetrics/gynecology—some health centers employ psychiatrists and a few have specialists such as general surgeons, geriatricians, rheumatologists or pulmonologists.

In 2008, these centers served more than 17 million unique patients with about 67 million visits. Included in that number are nearly 32 million visits to 8,445 primary care physician FTEs. About half of all community centers serve rural populations and offer sliding fee scales based on the patient's ability to pay. These health centers also receive higher Medicaid rates for primary care services, more than the Medicaid fee-for-service rates a private physician office would receive. The health center's cost-based reimbursement policy is required by section 330 of the Public Health Services Act.

Ron Yee, M.D., an Advisory Panel member who is chief medical officer at a seven-site community health center based in Parlier, California, says he does not have trouble recruiting physicians. Dr. Yee's organization, United Health Centers of the San Joaquin Valley, does not have heavy turnover. In fact, physicians who are not part of the NHSC program, in which they are working at the center in return for loan forgiveness, stay about ten years. Dr. Yee's experience is not unusual. According to a recent survey of 402 community health centers, annual turnover rates for physicians are relatively low, ranging from a high of nearly 8 percent to a low of less than 1 percent. (See chart.)

ANNUAL TURNOVER RATES

Family Practitioner no/OB	7.78%
Family Practitioner w/OB	0.75%
Internal Medicine Physician	4.75%
Pediatrician	3.68%
OB/Gynecologist	2.79%
Nurse Practitioner	8.36%
Physician Assistant	7.46%

Source: National Association of Community Health Centers.
Health Center Salary & Benefits Report 2009-2010.

Health Center Pay

While Dr. Yee noted that physicians may earn less base pay working at a community health center than in other venues, there are a number of opportunities to augment their incomes. While United Health Centers offers salaries that are 60 percent to 70 percent of the pay in Dr. Yee's local market, physicians also can receive a productivity bonus. Many health centers determine how many patients a clinician needs to see each day for the center to break even—at Dr. Yee's center that number is 23—and then set a bonus around that number. At United Health Centers, doctors who average have 23 appointments a day can receive about $17,000 annually in bonuses, while seeing 25 patients at day could result in nearly a $29,000 bonus.

Similar to a private practice, physicians can make more by working more. Dr. Yee noted that working on Saturdays, in addition to regular hours, garners extra pay, as does taking call. If a physician is willing to take call from the local hospital and the health center, Dr. Yee's organization adds $6,000 to the doctor's base salary. Physicians also earn additional money from the health center for each service they provide at the hospital, such as assisting with a delivery and providing follow-up care. "A physician could add $44,000 [annually] by working ten deliveries a month, [caring for the mother and baby] at the hospital," Dr. Yee noted.

Another addition to salary is the loan forgiveness program through the National Health Service Corps in which doctors can receive $145,000 in loan repayments over five years. After that period, physicians can renew the contract until all their loans are paid off.

According to NACHC's most recent salary survey, only about 12 percent of community health centers reward staff with retention bonuses, with average bonuses for physicians ranging from $467 to nearly $10,250. The average length of service to receive a bonus ranged from 3 to 4.4 years of service.[3] United Health Centers does not offer a retention bonus, but does offer a signing bonus ranging from $5,000 to $7,000, depending upon its needs and the physician's experience and qualifications.

Some physicians at Dr. Yee's community health center make more than $200,000 a year, adding salary, productivity bonuses, pay for taking call, and loan forgiveness. Dr. Yee pointed out these physicians are not concerned with overhead and hiring staff, and have medical, dental and retirement benefits. "Compared to working in a private practice, these doctors actually do pretty well financially," said Dr. Yee.

PERFORMANCE MEASURES

Health Centers Could Select More Than One Response.
Numbers From 402 Respondents.

RVUs	108
Patient Visits	313
Number of Capitated Lives	22
Case Management	76
Patient Satisfaction	312
Site Efficiency	133
Practice Productivity/Profitability	245
Other*	24

*Included gross billings, quality of care and teamwork.
National Association of Community Health Centers. Health Center Salary & Benefits Report 2009-2010.

PERFORMANCE MEASUREMENT USED FOR BONUSES

Health Centers Could Select More Than One Response.
Numbers From 402 Respondents.

RVUs	64
Patient visits	152
Number of Capitated Lives	6
Case Management	16
Patient Satisfaction	105
Site Efficiency	49
Practice Productivity/Profitability	131
Other*	31

*Includes gross billings, quality of care, teamwork
Source: National Association of Community Health Centers. Health Center Salary & Benefits Report 2009-2010

Benefits: Lifestyle and Practice Customization

Knowing that pay is not likely to be a health center's most attractive benefit for physicians, Dr. Yee tries to attract them with two benefits that are not related to income: lifestyle and practice customization. "We give them a lot of time off up front," said Dr. Yee, adding that the day a doctor starts, he or she has seven weeks of leave, including four weeks of vacation, a week of educational leave, and nine paid holidays, including the individual's birthday. Doctors do not have to take call, but if they do, Dr. Yee works to set a reasonable schedule, such as every sixth weekend and one day a week. Because each of the seven sites at United Health Centers is staffed with two to seven clinicians, full-time doctors—who work 40 hours a week—are not locked into a strict nine-to-five schedule. "We try to be reasonable and flexible to support clinicians and their families. If they intermittenly need to modify their schedules to attend family events we try to be accommodating," states Dr. Yee.

Part-time employment is also an option. At United Health Centers, two or three individuals can make up make up one FTE. Ten of the center's 25 doctors are part time. Dr. Yee added that because the center provides benefits at 20-hour-per-week level, most staff work at least that many hours.

"Our staff have flexibility and feel supported," said Dr. Yee.

Dr. Yee also works to make practice customization an option for the center's physicians. "I find out if there's a niche they want to fill, and allow them to do that." For instance, one physician prefers to perform procedures; she is able to perform many of the center's vasectomies and small surgical procedures. "We refer internally so she has a good case load to keep her skills up, and we are able to keep the cases internal to the center, so there is better continuity of care," Dr. Yee states.

In addition, physicians who want to teach have an opportunity to help train undergraduates and medical students because the center is an elective training site for University of California San Francisco. Eleven of the physicians at United Health Centers are associate clinical professors at the school.

Physicians also manage patient cases whose primary care provider is a mid-level clinician. In addition to 25 physicians,United Health Centers employs five physician assistants and two nurse practitioners. The center uses mid-levels not as physician extenders, but as practitioners. "They don't see only coughs, colds and the easy stuff," said Dr. Yee. If a mid-level has a more complex case he or she sees the patient most of the visits, and that patient might see a physician only once or twice a year. Essentially, the mid-levels have their own patient panels, says Dr. Yee, and whether the center can list the mid-level as the patient's primary care clinician depends on the payer. On the whole, though, this makes for more staff satisfaction for nurse practitioners and physicians assistants. "They like it because it uses all their skills," said Dr. Yee. "They feel good about their practice."

Through experimentation, Dr. Yee has also learned the staffing pattern it takes to make physicians satisfied with their work flow. The winning formula involves having three exam rooms and two medical assistants for each physician. Often patients at the health center only speak Spanish, so if a single medical assistant was on duty, he or she would be in an exam room translating for a physician. During that time, no other medical assistant duties would be performed, such as checking in patients or performing simple lab tests. "Without that ratio, we create a bottleneck," explained Dr. Yee.

Stepping Stone to Other Settings

Dr. Yee pointed out that most of the doctors he hires are mission-minded and fresh from residency. While community health center managers prefer and strive to have long-term relationships with physicians, these jobs can prepare physicians for private practice, in the event they choose to leave. This preparation is evident both in terms of complex cases and cutting edge projects in quality improvement. A number of community health centers have affiliations with university medical centers and participate in their quality initiatives. The health centers also help the doctors in developing diagnostic and treatment skills. "This setting provides some of the richest experiences medically, with a higher rate of chronic diseases and difficult cases," Dr. Yee stated. But a doctor going to work at a community health center today may not be using an electronic medical record; less than half of them have one.[4] United Health Centers and five other health centers received a $2.9 million grant in 2010 to implement electronic medical records. Dr. Yee expects his health center's electronic records system to be in place in 2012, and says other health centers will take similar initiatives. "They are all heading in that direction," he said.

In the Wake of Healthcare Reform Measures

While Dr. Yee believes the national healthcare reform law will help the uninsured—and the population community health centers serve—he is not certain how the law's provisions will affect his health center. NACHC estimates that their members will be able to double their capacity because of the additional funding, going from treating 20 million patients to 40 million by 2015. Toward that end, United Health Centers is gearing up to add space, breaking ground in 2010 on a 20,000-square foot administration building, freeing up more space for medical and dental care, and allowing the center to start offering behavioral health services. This expansion was funded in part by a $1.5 million federal grant from the 2009 American Reinvestment and Recovery Act. Dr. Yee predicted that his organization will add staff and extend hours.

But he is not sure if the future funding will ultimately bolster the center's operations. It currently receives a federal grant of $4.6 million annually to treat the indigent, and that amount could be decreased when more of the center's patients are covered by Medicaid. "We may gain on one side, but lose on the other. We could be in worse financial shape, depending on how the healthcare reform law is implemented in California," said Dr. Yee. "That's a question mark."

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Accountable Care Organization Study

Lehigh Valley Health Network
University of Michigan Faculty Group Practice

While the new healthcare reform law encourages clinical integration in a number of pilot projects, perhaps the most direct encouragement is the Medicare Shared Savings Program for Accountable Care Organizations (ACOs), slated to start in 2012. In these Medicare projects, provider organizations that meet specified quality standards and accept accountability for patients are able to share savings with the government. The organizations will enter into a three-year agreement and must be able to care for at least 5,000 Medicare patients. ACOs would not be penalized if they do not meet savings targets.[1]

Perhaps no part of healthcare reform has generated more activity on the part of provider organizations. News reports indicate that hospitals and physician groups are finding ways to connect now to be ready for the future.[2,3] And provider groups are spending considerable efforts to make sure they make the change completely and correctly. One example: about 80 provider organizations are studying ACOs in the Accountable Care Organization Learning Network, a joint project of the Engelberg Center for Health Care Reform at the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice. The program, which started in 2009, offers members monthly webinars and an ability to share best practices. In 2010–2011, the network will produce an implementation guide.[4] At the same time, Premier Health Alliance, a consulting and purchasing network owned by not-for-profit hospitals, is working on two collaboratives designed to help members develop the capabilities necessary for ACOs. One collaborative works on ACO readiness, while another is focused on implementation.[5]

While hospital systems and networks are investigating the transformation to ACOs, Advisory Panel members recommended that physicians should lead such organizations. They are not alone. Harold D. Miller, Executive Director of the Center for Healthcare Quality and Payment Reform, writes in a recent White Paper produced for AMA members that there is little evidence to prove that any particular type of provider or organizational structure cannot serve an as Accountable Care Organization. . . The goal of the Accountable Care Organization is to take responsibility for managing the costs and quality of healthcare for a population of patients, not necessarily to deliver every health service itself.[6] In fact, CMS indicates that physicians in group practices and networks of practices are ACO candidates.[7]

A growing number of hospitals are planning on acquiring group practices or employing physicians, in part to prepare for the ACO model (see chart below).

PHYSICIAN/HOSPITAL ALIGNMENT

According to a survey of 258 hospital leaders:

74% say they plan to employ a greater number of physicians in the next 12 to 36 months

70% say they have received increased requests from physician group for employment

61% plan on acquiring medical groups in the next 12 to 36 months

*Includes gross billings, quality of care, teamwork
Source: National Association of Community Health Centers. Health Center Salary & Benefits Report 2009-2010

Principles of the ACO Model

1) Local accountability: ACOs will be comprised of local delivery systems with patients empirically assigned to the organization. ACO spending benchmarks will be based on historical trends and adjusted for patient mix, making the local system account for cost, quality and capacity.
2) Shared savings: ACOs with expenditures below their benchmark will be eligible for shared savings payments. Savings can be shared among all stakeholders and allow for investment that can improve care and slow cost growth.
3) Performance Measurement: Measurement is essential to ensure that appropriate care is being delivered and that cost savings are not the result of limiting necessary care. ACOs will report patient experience data in addition to clinical process and outcome measures.

Source: Brookings-Dartmouth ACO Learning Network. Overview of the ACO Model.

Requirements for an ACO

1) Formal legal structure to receive and distribute shared savings.
2) Sufficient number of primary care professionals for the number of assigned beneficiaries (5,000 minimum).
3) Participation in the program for at least three years.
4) Sufficient information regarding participating ACO healthcare professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared saving.
5) A leadership and management structure that includes clinical and administrative systems.
6) Defined processes to promote evidenced-based medicine, report the necessary data to evaluate quality and cost measures, and coordinate care.
7) Meet patient-centeredness criteria, as determined by the Secretary.

Source: CMS/Office of Legislation. Medicare Accountable Care Organizations Shared Savings Program, Preliminary Questions and Answers. June 2010.

ACOs are not just groups of aligned providers. For most physician practices or networks, substantial investment in technology and staff commitment to change processes has to take place. These organizations not only track a patient's medical record to various providers, but must develop the ability to meet benchmarks on quality standards. Following are two case studies of organizations preparing to be able to contract with Medicare as an ACO. One is a private health network in Pennsylvania that is working to align with its physicians, both in employed and unemployed models, in an effort to improve cost and quality metrics. Another is an academic physician practice that participated in the CMS Medicare Physician Group Practice Demonstration Project to drive its performance to a higher level.

Case Study: Lehigh Valley Health Network, Aligning With Physicians

Organizations like the Lehigh Valley Health Network, which include physicians and hospitals under one umbrella, are arguably the most likely ACO models. The network, based in Allentown, Pennsylvania, includes two hospital campuses with 1,000 beds and a hospital-owned 500-doctor multi-specialty practice, and another 200 doctors that are exclusively aligned, that is, they practice medicine only at Lehigh Valley hospitals.

Michael Rossi, M.D., an Advisory Panel member and a cardiologist who serves as the executive director of the network's physician practice, Lehigh Valley Physician Group, noted that the journey to alignment with hundreds of doctors was a long one. The hospital-owned physician practice began in 1992 as a place to employ physicians in support specialties for the hospital, such as the surgeons who operated on trauma patients and burn victims. The practice also was home to faculty that trained residents. When it started, the group totaled 24 doctors.

Over the next ten years, the practice saw a gradual increase, precipitated by physician and community need. For instance, when Pennsylvania medical malpractice premiums soared in the mid and late 1990s, ob/gyns who wanted to stay in the area joined Lehigh Valley's physician group. They no longer paid high premiums, as this cost was born by the physician group. Pediatricians followed the obstetricians into the employed group. In the last decade, when many specialists began to charge to take call at hospitals or simply no longer performed that service, the employed practice welcomed specialists who would perform that service, in turn ensuring that the network's hospitals had coverage. Dr. Rossi said that the network also has acquired some primary care practices whose doctors wanted to access the network's electronic medical record and to participate in its quality initiatives.

Dr. Rossi has some experience creating larger practices. When he came to Allentown in 1992, he joined one of the two "large" cardiology practices in town. Each had about ten physicians. He realized that the practice wasn't reaching its fullest potential because it spent most of its energy competing with the other large practice in town. The doctors were trying to get primary care physicians to change their referral patterns instead of being focused on quality, program development and growth. "We were trying to get a bigger piece of the pie instead of growing the pie," states Dr. Rossi.

Eventually, he became managing partner of the practice and helped facilitate the merger of the two large cardiology practices. He also championed a closer alignment with the hospital: The cardiology practice moved onto rented space at the hospital campus in the late 1990s and several of the practice members became involved in program leadership at the hospital. One physician became director of the cardiac cath laboratory, another become the director of the electrophysiology laboratory, for which they received small stipends, while they continued to practice medicine. In turn those

physicians had influence on how the hospital's program developed regarding treatment protocols. The cardiology practice was able to add additional sites, treating more patients, creating opportunities for both the practice and the hospital. Dr. Rossi himself later served as the first full-time chief of cardiology for the network, before he assumed his current role with the employed group practice.

Dr. Rossi attributed the success of the hospital's efforts with physicians to two principles. First, there was an understanding between physicians in the community and the hospital that the hospital would not aggressively pursue physicians to have them join the hospital-owned practice. "The employed physician group would only respond if we were approached," said Dr. Rossi. "That way the hospital wasn't seen as pushing private practice out." A legacy of that decision is evident in the fact that 300 physicians not exclusively aligned with the Lehigh Valley Health Network still are part of its active medical staff.

Second, the hospital made it clear it was serious about closer alignment with physicians and that they didn't have to be employees. The network uses clinical affiliation agreements, similar to the one which was used with Dr. Rossi's practice. Another example involves a pulmonary critical care group with which the hospital contracts. The hospital helped fund technology and additional staffing for an advanced ICU, with after-hours coverage by a remote intensivist, which resulted in improved cost and patient outcomes for the hospital. The pulmonary critical care practice is now able to care for more patients as a result of these upgrades.

Lehigh Valley Health Network also leases practices and offers private practice physicians the opportunity to be voluntary clinical faculty.

The network has a Physician Hospital Organization that contracts for an Independent Practice Association that is only open to members of Lehigh Valley's Medical Staff. "There's a vision that the PHO could be a way to spread the network's electronic medical record to community physicians, but we haven't done that yet," states Dr. Rossi.

Financial Integration

In his role as executive director of the employed physician group, Dr. Rossi is working on converting 39 different compensation models to just one. As contracts expire, physicians are transferred to the new compensation plan, a model in aligning financial and quality incentives.

The new compensation plan includes a salary based on benchmark data, with a productivity expectation built in to it, and the salaries have a 2.5 percent to 10 percent withhold—departments within the practice can choose the level. "It's not a lot of money, but it's enough to get doctors' attention," stated Dr. Rossi. This money is returned to physicians based on minimum standards including such areas as patient satisfaction, quality metrics, graduate medical education, and cost effective care. "It's not meant to be a high bar, but create a threshold at a place where we didn't have one before," said Dr. Rossi.

A third piece of the employed doctors' compensation involves an incentive plan in which physicians share in dollars generated when the 90 practices within the employed group perform better financially than the projected budget. That money is distributed based on the performance of the individual practices, the 500-physician group practice and the network. Individual departments or divisions within the Lehigh Valley Physician Group can set the metrics for doctors to receive those

dollars. Dr. Rossi pointed out that physicians get the maximum incentive payment, which can be up to 10 percent of their salary, if all three entities perform well. By connecting the doctors to the overall network this way, stated Dr. Rossi, they have a vital reason to be involved. "If you are working on reducing length of stay or the cost of surgical equipment, now the doctors are engaged—before it was a burden."

While the network has been able to create Valley Preferred PPO that serves more than 200,000 patients, Dr. Rossi believes that network hasn't reaped the full benefits of its effort because payment in the market is still largely fee-for-service. Half of the payer mix for the practice is fee-for-service or managed care discounted fee-for-service, 30 percent Medicare, 10 percent Medicaid and another 10 percent self-pay. But Dr. Rossi predicts a change. "Whether it's an accountable care organization model, where the ACO accepts global capitation, or Medicare moving to value-based purchasing, global payment or bundled payments, it makes sense for the hospital and physician to be aligned and to be as integrated as possible."

For Dr. Rossi, the alternative is untenable. He describes a possible future scenario in which a payer remits $1,000 to a hospital for a cardiac care episode, which it must divide among all the doctors who cared for the patient. "Who's going to negotiate those different fee schedules?" he asked. "It becomes a nightmare."

But before such payment types arrive in Allentown, Lehigh Valley Health Network continues to work on alignment, in various forms. The network is currently leasing a primary care practice for seven years. "We are setting the expectation that if doctors want to partner with us, they must do it exclusively," stated Dr. Rossi. "If the future is about efficiency, quality and standard work practices, we can't see existing in a world where doctors are going to three different hospitals and learning three different medical record systems. It's about focusing your energy to produce better quality and greater value."

Case Study: University of Michigan Faculty Group Practice and the Medicare Pay for Performance Demonstration Project

In the mid-2000s, the University of Michigan Faculty Group Practice plan had a number of pieces in place to enable it to deliver high quality care, but David Spahlinger, M.D., an internist and Advisory Panel member who is executive director of the faculty group practice, wanted to see performance improve even more. In fact, he thought it was a necessary step for the practice to continue to thrive.

Dr. Spahlinger, who also serves as clinical associate professor of internal medicine and senior associate dean for clinical affairs at University of Michigan's medical school, championed the faculty practice's participation in Medicare's Physician Group Practice Demonstration. This pay-for-performance project allowed practices to share in cost savings. Even with the resources of a large practice—the University of Michigan group includes 1,700 doctors who care for patients at three university hospitals and 40 university health center—participating in this project required a substantial investment.

"I had to ask for $800,000 for the infrastructure," stated Dr. Spahlinger, "but I convinced the board this would position us for the future."

The Medicare demonstration project was mandated in the Medicare, Medicaid and SCHIP Benefits and Improvement Protection Act of 2000, with the goals of:

> Encouraging coordination of Part A and Part B medical services, promoting cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams, and rewarding physicians for improving health outcomes.[8]

In the demonstration project, practices continue to be paid Medicare fee for service rates. The savings the group practices generate are judged by comparing its Medicare patients to local market Medicare patients not served by those providers, adjusted for case mix. After practices meet a 2 percent savings threshold, they can earn up to 80 percent of the savings they generate, while the Medicare trust fund retains the other 20 percent. Practices earn the payments both by demonstrating savings and reaching benchmarks on quality measures.

The program started in 2005 with only 10 quality measures for diabetes patients. More measures were added, so that at year three and after, 32 such measures in five different disease modules are assessed by Medicare.

See below the measurements in the Heart Failure module:

PHYSICIAN GROUP PRACTICE DEMONSTRATION QUALITY MEASURES FOR HEART FAILURE PATIENTS

1) Left ventricular function assessment
2) Left ventrical ejection faction testing
3) Weight measurement
4) Blood pressure screening
5) Patient education
6) Beta-Blocker Therapy
7) Ace Inhibitor Therapy
8) Warfarin Therapy for Patients with Atrial Fibrillation
9) Influenza Vaccination for HF patients 50 years and older
10) Pneumonia Vaccination for HF patients 65 years and older

Source: CMS. Physician Group Practice Demonstration Quality Measurement and Reporting Specifications, Version 2. 2005.

For each measure, group practices can satisfy quality requirements in several ways: reaching a certain percentage of compliance; reaching a percentage benchmark based on indicators from the Medicare Health Plan Employer Data and Information Set (HEDIS) scores; or registering a certain percentage of improvement in compliance over previous years. The quality performance payment is based on the percentage of the quality targets a practice has met in the project year. During the first three years of the project, the weighting of savings and quality measures shifted from 70 percent based on savings and 30 percent based on quality measures to a 50/50 percent split.[8] "If you don't hit the benchmarks on the quality measures," stated Dr. Spahlinger, "you can lose half of your performance payment."

At the time the Michigan faculty practice began the program in 2005, it already had quality initiatives in place and a robust information technology program, with a disease registry and tracking systems. But the practice added a complex care management group made up of nurses and social workers. This group identifies high risk patients and makes sure the patients have timely follow-up appointments after inpatient discharges and emergency department visits.

In fact, Dr. Spahlinger pointed to this program as the one that helped the practice succeed. "Caring for the highest cost, most complex patients—end stage renal disease, heart failure patients—that's where we saved money," he said. Dr. Spahlinger makes the point that to reduce costs, providers need to aim at preventing hospital readmissions. Providers do not save the Medicare program money by reducing length of stay because hospitals receive one payment for the stay through DRG methodology. In order to stop readmissions, said Dr. Spahlinger, providers need to keep in touch with these patients, making sure they get the necessary interventions, medications and care. "Patients are pretty sick when you discharge them from the hospital now," he added. "You don't want them waiting two weeks for a follow-up appointment."

The Michigan faculty practice was successful in saving $34 million over risk-adjusted expected costs over a four-year period, treating 18,000 to 20,000 patients in each year of the program. The practice retained savings expected to be in excess of $12 million for the four-year period. Dr. Spahlinger pointed out that practices must wait for their performance payments; it takes about a year for the data to come back. In August of 2010, the practice did not have data for the fifth year of the project, which ended March 31, 2010. In addition, CMS withholds 25 percent of its performance payments to the practice, to use in case the practice loses instead of saves money the next year.

During the project, the Michigan faculty practice had its share of challenges. The percentage of Medicare Advantage patients that were attributed to the practice increased from 4 to 25 percent. These patients tend to be healthier and they are excluded from the pay-for-performance project. The practice found its percentage of high-risk patients—those needing costly care—increasing as a result.

Dr. Spahlinger also pointed out that patients are assigned retrospectively, that Medicare looks at where patients get a plurality of their care for attribution to the practice. "This is really managed care, but we are putting it on top of a fee-for-service free-for-all," he said. For the program to be effective, patients should choose a primary care provider and then let him or her manage their care prospectively, he argued. The practice treats some 40,000 Medicare patients, but only about half that amount was considered to be attributed to the demonstration project.

"We had to cast a much wider net," stated Dr. Spahlinger, noting that many patients that received the benefit of all the practice's quality programs were not counted by Medicare. "All these patients received better care, but we have to concentrate our dollars where they will have the most benefit," said Dr. Spahlinger. "If we had been able to better focus our resources, we could have had better results."

But this hasn't dampened his enthusiasm. The practice is already negotiating a continuation of the pay-for-performance project. Dr. Spahlinger said the past participation will make it easy for the practice to take on an ACO shared savings contract, as the new Medicare project will have a similar design.

And aside from improving quality and gaining performance payments, the project has led to another positive change at the faculty practice—a more collaborative culture. Leaders at the practice had wanted staff to improve their ability to work together across departments and as a whole. "The best way to do this is to provide shared responsibility," said Dr. Spahlinger. "A project like this ends up bringing people together to solve problems."

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Affiliated Rural Group Case Study: Medical Associates

Rural healthcare delivery has traditionally faced a wide range of siginficant challenges. Patient populations tend to be older and more dispersed, and rural clinicians often have to work longer hours to care for patients. It's also harder to attract physicians to rural areas. The raw numbers bear this out—19.2 percent of the U.S. population live in rural areas, but only 11.4 percent of physicians practice there.[1] A number of measures in the ACA strive to bolster rural healthcare delivery and to increase the number of physicians practicing in rural areas (see "Health Reform and the Physician Work Force" in this paper.) While health reform provisions may help, they are not enough to change the market conditions that are forcing some rural practices to make changes and seek new partners.

Medical Associates, a six-doctor practice in Le Mars, Iowa, sits in a town of 9,000 in the rural Midwest, with a market area that is home to 20,000 potential patients. The practice came to the decision in 2008 that it had to take action to insure its future. The primary impetus was that it could not recruit physicians. "Most candidates were not willing to buy into a practice," said practice administrator Julie Sitzmann, who has been at her job for 18 years. "We were going to be in a better position for recruitment if we were part of a system." The changes, though not directly driven by health reform, better position the practice to operate in the post-reform environment, Sitzmann indicates.

The practice hired a consultant in the spring of 2008 to help the physicians consider their options. It considered selling to large systems outside of Le Mars and a large physician group in Sioux City, Iowa. In the end, the practice rejected these potential partners. "We didn't have the same agenda," said Sitzmann. She explained that the large health systems wanted to buy the practice for its hospital admissions, but that would have forced both doctors and patients to drive out of town for routine inpatient care. Another concern was that the large physician group would enter contracts with payers that weren't favorable to Medical Associates. "In Sioux City, that group is one of several providers, where as we are the only game in town," said Sitzmann. This gives Medical Associates bargaining power that might not be reflected in the larger group's negotiations.

In the end, Medical Associates, now called the Family Medicine Clinic, chose Floyd Valley Hospital located in Le Mars. "We could get the best deal from the hospital," said Sitzmann, "because it had the most to gain from owning us." The clinic began operation as a hospital department July 1, 2009.

Floyd Valley Hospital, a 25-bed critical access facility with 300 employees, has realized improvements from the purchase. With the doctors and hospital as one entity, the organization was able to change to the more favorable Provider-Based Medicare reimbursement, adding about 10 percent more to its Medicare revenues.

"Medicare and other payers were nudging us together," said Mike Donlin, who has served as the hospital's administrator for 12 years. "We've had a long courtship. The hospital always let it be known that we were willing to talk."

Donlin does not want to repeat the problems of the hospital practice purchases of the 1990s. "We are not making any sudden drastic changes," he noted, adding that practice was not in distress before the purchase. The doctors still have much influence in how the practice is run, comprising four of six voting members on the clinic operations committee. Donlin and the hospital's director of finance are the other voting members.

In the purchase arrangement, the hospital owns the practice, but the physicians are employees of the Avera Medical Group, which provides a benefit package for the physicians. Avera Medical Group is part of Avera, a health system based in Sioux Falls, South Dakota, with which Floyd Valley Hospital has an affiliation. The other employees of the Family Medicine Clinic, including three physician assistants and five nurse practitioners, are employed by the hospital.

The hospital has a lease agreement with Avera Medical Group for the doctors' services. Pay is structured on a productivity basis using RVUs, similar to how the doctors were paid before the purchase. The agreement includes a four-year guaranteed minimum and a ceiling, with doctors earning 85 percent to 125 percent of their previous income. "We wanted to do something straightforward the first few years in which doctors could make about what they made in private practice," stated Donlin. In some ways, the arrangement is seamless: the practice continues to be at the hospital, where it leased space before the purchase, and Floyd Valley Hospital hired Sitzmann to continue as administrator.

Sitzmann and Donlin hope the practice purchase will allow new efficiencies, and it is already bearing fruit. The merger of the practice and hospital radiology departments is saving money and eliminating duplication. "We haven't tinkered with back office or lab operations," noted Donlin. "The hospital won't dictate those kinds of changes, and the clinic operations committee will do what makes sense."

More changes are in the offing. The practice is trying to recruit two family practice physicians that practice obstetrics, which Sitzmann is hoping will be easier with an employed model. The practice lost two physicians in the last four years, creating hectic call schedules for the physicians who practice obstetrics. "These physicians are on call every fourth night and every fourth weekend, and that is too much," said Sitzmann.

But the physicians also have another purpose in making new hires. "We see that reimbursement is going toward being value-based, rather than volume-based," said Sitzmann, "so we want our doctors to be able to spend more time with patients and more time coordinating their care." These changes, she said, will help the doctors position the practice to be a candidate for the National Committee on Quality Assurance's medical home designation. "In merging with the hospital, the doctors had the future in mind," said Donlin.

1. Rosenblatt, R., et. al. The Future of Family Medicine and Implications for Rural Primary Care Physician Supply. WWAMI Rural Health Research Center. August 2010. depts.washington.edu/uwrhrc/uploads/RHRC_FR125_Rosenblatt.pdf

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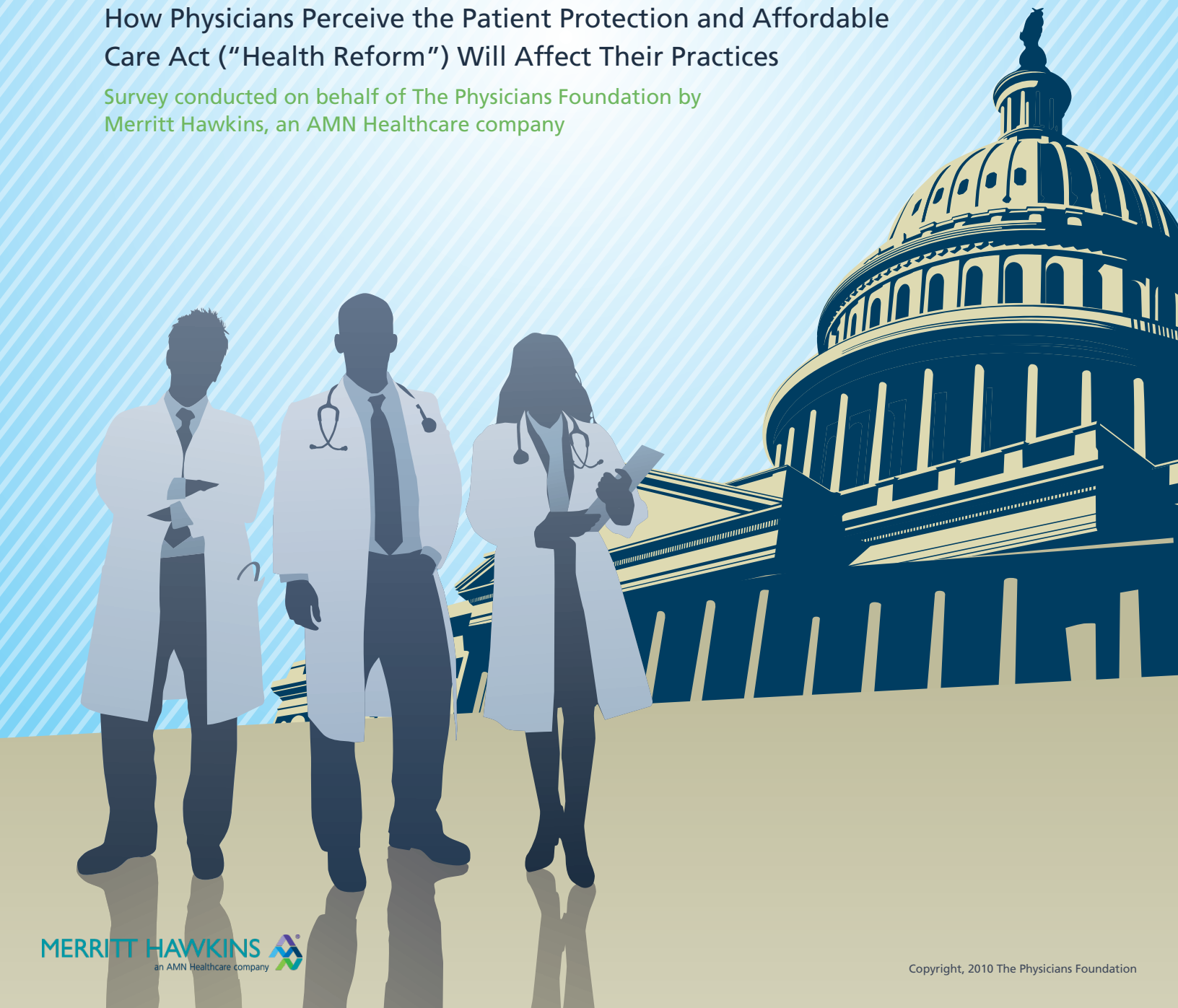
2010 Survey: Physicians and Health Reform

How Physicians Perceive the Patient Protection and Affordable Care Act ("Health Reform") Will Affect Their Practices

Survey conducted on behalf of The Physicians Foundation by Merritt Hawkins, an AMN Healthcare company



MERRITT HAWKINS
an AMN Healthcare company

EXECUTIVE SUMMARY

A View From the Front Lines

Though healthcare delivery in the United States continues to evolve, physicians remain at the center of the system.

It is physicians who provide the diagnoses, conduct the procedures and order the tests and treatments that constitute the core of patient care. Despite the valuable contributions of various other types of clinicians, physicians are the key professionals on whom the timely, efficient and effective delivery of care depends. The physician's pivotal role is underscored by the fact that physician decisions drive 80% or more of total health care spending*

In assessing how healthcare is delivered in the United States, therefore, it is entirely appropriate and necessary that the physicians' voice be heard.

This survey was conducted as part of The Physicians Foundation's ongoing mission to incorporate the physicians' perspective into national healthcare policy discussions. It is the second national survey of physicians The Physicians Foundation has conducted to learn how physicians on the front lines of medical care view the current medical practice environment. The Physician Foundation's initial survey, *Medical Practice in 2008: The Physicians' Perspective,* examined the state of physician morale and physicians' attitudes towards the practice of medicine. The survey concluded that many physicians are dissatisfied with the conditions under which they are compelled to practice, and that many plan to retire, transition out of patient care roles, or take steps that will result in reduced patient access to their practices.

Some 4,000 of approximately 12,000 physicians who responded to the 2008 survey provided written comments appraising the current state of the medical profession. These comments formed the basis of a book published by The Physicians Foundation entitled, *In Their Own Words: 12,000 Physicians Reveal Their Thoughts on Medical Practice in America.*

The 2010 Physicians and Health Reform Survey continues The Physicians Foundation's ongoing dialogue with doctors on the front lines of care, with a specific focus on how physicians perceive the Patient Protection and Affordable Care Act ("health reform") will affect their practices. The survey is intended to gauge physicians' initial reaction to health reform and to learn the ways in which they plan to respond to it.

A Continuing Erosion

Conducted in June, July and August of 2010 by Merrit Hawkins, a national physician search and consulting firm, the survey offers a snapshot of how physicians responded to the health reform bill some three to four months after it became law. As health reform is implemented, physician attitudes may change. However, the survey suggests that physicians' assessment of health reform in its early stages is predominantly negative, perhaps in part because they do not believe they had sufficient input into the new law. A great majority of physicians indicated that the physician's perspective was not adequately represented to policy makers during the run-up to health reform.

*Crosson CJ, Tollen, LA. Partners in Health: How Physicians and Hospitals Can be Accountable Together. Copyright 2010 by Kaiser Institute for Health Policy. Jossey-Bass Publishers.

The survey makes clear that physicians are dubious about how health reform will affect the quality of care they are able to provide to patients, the financial viability of their practices, and the long-term future of the traditional independent private practice model. In response to health reform, many physicians indicate they will take steps that will reduce patient access to medical services, accelerating a trend observed in The Physicians Foundation's 2008 survey.

The survey suggests that physicians will adopt a variety of practice styles—including hospital employment, part-time practice, locum tenens and concierge practice—further driving a trend toward a heterogeneous physician workforce no longer composed primarily of full-time, private practitioners.

Rather than a sign of progress, the survey suggests that most physicians view health reform as a further erosion of the unfavorable medical practice environment with which they must contend.

Summary Statement

It is The Physician Foundation's position that a robust and engaged medical profession—one capable of attracting talented newcomers and retaining experienced professionals—is essential to the viability of America's healthcare system. The survey suggests that health reform, at least in its initial stages, has further disengaged doctors from their profession, with potentially negative consequences for both the medical profession and for the quality and accessibility of medical care in the United States.

METHODOLOGY

The Physicians Foundation's 2010 Physicians and Health Reform survey was mailed by Merritt Hawkins to 40,000 physicians engaged in active patient care throughout the United States. Physician names were generated at random from the American Medical Association's Physician Master File database. Surveys were mailed in mid-June to physicians in 10 medical specialties, including family practice, internal medicine, pediatrics, obstetrics/gynecology, cardiology, orthopedic surgery, radiology, anesthesiology, general surgery and hospitalist (in-patient) medicine.

Twenty-five thousand of the surveys (63%) were mailed to primary care physicians (family practitioners, general internists, pediatricians) while the remainder were mailed to surgical, diagnostic and inpatient medicine specialists. The survey was weighted toward primary care physicians, who comprise 35% of all physicians in active patient care, because they are on the front lines of healthcare delivery and will be the first physicians expected to accommodate the influx of newly insured patients health reform will create.
In addition to the mailed survey, an electronic version of the survey was emailed in mid-August to approximately 60,000 physicians on Merritt Hawkins' proprietary database. Of these, 56% are in primary care. A total of 2,379 completed surveys were received by August 23, 2010, for an overall response rate of 2.4%.

Accuracy Statement

Survey response data was submitted for analysis to an expert specializing in statistical response at the College of Business Administration at the University of Tennessee, Knoxville.

A written report (report available by request) was submitted regarding overall response and individual response items. The General Assessment includes the following accuracy statement regarding the survey:

*"The overall margin of error for the entire survey is +/- **1.93%**, indicating a low sampling error for a survey of this type (i.e., less than 2% error). However, the error rate fluctuates across questions within the survey according to individual questions and response items within questions, and thus care should be exercised in interpreting results."*

THE UNIVERSITY of TENNESSEE KNOXVILLE

Written Comments

In addition to completing a series of multiple choice questions, the survey asked physicians to provide a written statement regarding what they would like the public and policy makers to know about health reform and the state of medical practice today. Over 1,200 physicians, or 50% of total respondents, provided written statements. A selection of these statements is included in this report.

KEY FINDINGS

Responses to the survey combined with written comments received from physicians strongly indicate that most physicians are not favorably disposed toward health reform and are pessimistic about its potential effects on their practices. As reform is being implemented, many physicians plan to take steps that would remove them from patient care or limit patient access to their practices.

Key findings of the survey include:

- 67% of physicians said their initial reaction to passage of the 2010 Patient Protection and Affordable Care Act was either "somewhat negative" or "very negative."
- With several months to consider the content and direction of the new law, 39% of physicians said they are now more negative about health reform than they were when it initially passed, compared to only 10% who now are more positive about the law than when it initially passed.
- In response to reform, 74% **of physicians said they would take steps to change their current practice style** in the next one to three years. Only 26% said they would continue as they are.
- 40% of physicians said they would drop out of patient care in the next one to three years, either by retiring, seeking a non-clinical job within healthcare, or by seeking a non-healthcare related job.
- The majority of physicians (60%) said health reform will compel them to **close or significantly restrict their practices to certain categories of patients.** Of these, 93% said they will close or significantly restrict their practices to Medicaid patients, while 87% said they would close or significantly restrict their practices to Medicare patients.
- The great majority of physicians surveyed (86%) believe the viewpoint of physicians was not adequately represented to policy makers during the run-up to passage of health reform.

- While over half of physicians said health reform will cause patient volumes in their practices to increase, 69% said they **no longer have the time or resources to see additional patients** in their practices while still maintaining quality of care.
- The majority of physicians (59%) said health reform will cause them to spend less time with patients.
- Only 10% of physicians said reform will improve the quality of patient care they are able to provide, while 56% said reform will **diminish the quality** of care they are able to provide.
- About half of physicians (49%) said their attitude toward medicine was "somewhat negative" or "very negative" before health reform was enacted. Since reform was enacted, about two-thirds (65%) said their attitude toward medicine was "somewhat negative" or "very negative."
- The great majority of physicians (89%) believe the traditional model of independent private practice is either "on shaky ground" or "**is a dinosaur soon to go extinct.**"

The great majority of physicians surveyed (86%) believe the viewpoint of physicians was not adequately represented to policy makers during the run-up to passage of health reform.

Survey Questions and Responses

1) What is your medical specialty?

Family practice	26%
Internal medicine	6%
Other	11%
Pediatrics	9%
Anesthesiology	8%
Ob/Gyn	7%
Orthopedic surgery	7%
General surgery	%
Radiology	5%
Cardiology	3%
Hospitalist	2%

The primary care specialties—family practice, internal medicine, and pediatrics—are among the largest in medicine, and physicians in these specialties accounted for the largest per specialty response. However, while approximately 60% of all surveys were sent to primary care physicians, primary care physicians accounted for only 47% of total responses, indicating that specialist physicians responded to the survey at a somewhat higher rate than did primary care doctors.

2) What is your age?

<35	8%
36-40	12%
41-45	15%
46-50	15%
51-55	22%
56-60	20%
61-65	5%
>65	3%

Physicians in active patient care are almost evenly divided between those who are 51 and older and those who are 50 and younger.** This divide is reflected in survey responses. About half of respondents (48%) are 51 or older while the remaining 52% are 50 or younger.

3) How many years have you been in medical practice (post residence/fellowship?)

0-5 years	14%
6-10 years	15%
11-15 years	16%
16-20 years	17%
21-25 years	17%
26+ years	21%

The majority of respondents (86%) are experienced physicians who have been in medical practice six years or more and have had a chance to learn both the clinical and financial/administrative sides of medicine and how these may be affected by changes in policy.

4) What state do you practice in?

California	8.4%
Texas	6.7%
Florida	6.2%
New York	5.4%
Pennsylvania	5.3%
Ohio	3.8%
Georgia	3.6%
North Carolina	3.6%
Missouri	3.2%
Illinois	3.5%
Michigan	3.0%
Virginia	2.8%
Arizona	2.4%
New Jersey	2.3%
Colorado	2.3%
Tennessee	2.3%
Louisiana	2.2%
Wisconsin	2.1%
Indiana	1.9%
Kansas	1.9%

AMA Physician Master File

Maryland	1.8%
Massachusetts	1.7%
South Carolina	1.7%
Alabama	1.6%
Minnesota	1.6%
Washington	1.6%
Connecticut	1.1%
Kentucky	1.0%
Oklahoma	1.0%
Oregon	1.0%

All others less than one percent

The top ten states listed above—California, Texas, Florida, New York, Pennsylvania, Ohio, Georgia, North Carolina, Missouri, Illinois—accounted for 46% of responses. Fifty-two percent of active physicians in the U.S. practice in these states. Response volumes by state generally are reflective of physician numbers by state.

5) Are you in an independent, physician-owned practice or are you employed by a hospital, health system or other entity?

Physician-owned practice	59%
Employed by hospital or other entity	41%

As noted elsewhere in this paper, physicians in recent years have been moving away from the traditional, independent private practice model toward employment by a hospital or other organization. The Medical Group Management Association reports that 52% of physicians are now employed. The majority of survey respondents (59%) are in private practice, however, and survey responses therefore may be weighted toward the private practice perspective.

6) What was your initial reaction to passage of the 2010 Patient Protection and Affordable Care Act?

Very positive	12%
Somewhat positive	15%
Neutral	6%
Somewhat negative	15%
Very negative	52%

Few physicians surveyed were on the fence regarding health reform when it passed in March, 2010. The initial reaction of over two-thirds of physicians was either somewhat or very negative, compared to 27% who were somewhat to very positive about the new law. Only 6% described their initial reaction as neutral.

7) How do you now feel about health reform?

I am more positive than I was initially	10%
My feelings have not changed	51%
I am more negative than I was initially	39%

Survey respondents had three to four months after passage of health reform to study the provisions of the law and consider its implications. For a few (10%) the passage of time has led them to view health reform more favorably than they did initially. The majority (52%) did not revise their original opinion, however, while almost four in ten now feel more negatively about the law than they did initially.

CHANGING THEIR OPINION

Of those physicians who said they initially were either "very positive" or "somewhat positive" about passage of health reform, 24% said they are now more negative.

Of those physicians who said they initially were either "somewhat negative" or "very negative" about passage of health reform, only 3% said they now are more positive.

The survey indicates that the three to four month "cooling period" after passage of health reform did little to change the minds of those physicians who initially were unfavorably disposed toward the law. By contrast, one quarter of those physicians who initially were favorably disposed toward the law have since revised their opinion.

8) Do you believe the viewpoint of physicians was adequately represented to policy makers and the public during the run-up to passage of health reform?

Yes	14%
No	86%

Physicians approached unanimity in believing that their viewpoint was not conveyed to policy makers during the preamble to health reform. The American Medical Association, still the largest group in organized medicine, endorsed healthcare reform, though many physicians at the grass roots level were not in favor of the law, as this survey suggests. This disconnect between the AMA and many rank and file physicians, and the status and direction of organized medicine in the post-reform era, are addressed separately in this White Paper.

9) How do you think reform will affect patient volume at your practice?

Patient volume will increase	54%
Patient volume will remain the same	35%
Patient volume will decrease	11%

The majority of physicians (54%) anticipate that health reform will increase patient volume at their practices as more patients obtain health insurance over the next several years. Over one-third, however, do not think volume in their practices will change. These physicians may have largely Medicare practices, may practice in areas that have a high concentration of privately insured patients, or be otherwise positioned so as not to be affected by an influx of patients insured through Medicaid or new insurance exchanges. About one in ten physicians indicated they believe volumes in their practices will decrease, perhaps because they anticipate some of their patients may lose or change the coverage they currently have.

10) Do you now have the time and resources to see additional patients in your practice while still maintaining quality of care?

Yes	31%
No	69%

Though the majority of physicians anticipate rising patient volumes in their practices post-reform, most doctors surveyed (69%) report they are already too busy or are otherwise unequipped to see additional patients in their practices while continuing to maintain quality of care. How an already extended physician workforce will cope with an influx of newly insured patients is addressed separately in this paper.

11) How do you believe reform will affect the quality of care you are able to provide to your patients?

Improve	10%
No effect	19%
Diminish	56%
Unsure	15%

Only one physician in ten believes that health reform will enhance the quality of care they are able to provide to their patients, compared to 56% who believe reform will diminish the quality of care they are able to provide.

12. How many hours do you now work a week (including clinical and non-clinical tasks)?

0-20	2%
21-30	5%
31-40	11%
41-50	23%
51-60	31%
61-70	13%
71-80	11%
81-90	1%
91-100	1%
100+	2%

The majority of physicians (82%) report working a full-time schedule of 40 hours or more a week, while 59% report working 50 hours a week or more. Over one-quarter (28%) report working 60 hours a week or more.

Eleven percent of physicians are working an intermediate schedule of 31-40 hours a week, somewhere between full time and part-time, while 7% of physicians are working a part-time schedule of 20 hours a week or fewer. While access to medical services is being maintained in part by physicians working long hours, it has been observed that physicians are working fewer hours per week today than they have in the past. Any reduction in the number of physicians working a full schedule could have a significant impact on patient access to services, a topic examined in more detail in this paper.

13) How do you believe health reform will affect the amount of time you are able to spend per patient?

I will be able to spend more time per patient	3%
There will be no change in the amount of time I can spend per patient	24%
I will have to spend less time per patient.	59%
Unsure	14%

The majority of physicians (59%) said that health reform will cause them to spend less time per patient, about the same number who indicated that health reform will diminish the quality of care they are able to provide to patients.

14) What effect do you believe reform will have on the financial viability of your practice?

Enhance	10%
No effect	9%
Diminish	68%
Unsure	13%

Most physicians are not optimistic about the effect health reform will have on the financial position of their practices. Over two-thirds (68%) believe reform will reduce the financial viability of their practices, compared to only 10% who believe the financial viability of their practices will be enhanced by health reform.

Though reform will reduce the number of patients who are uninsured, it creates uncertainty among physicians about reimbursement levels they are likely to see from the new insurance exchanges and from Medicaid. Some physicians may be worried that insurance companies will cover the increased costs they face by cutting physician payments, or that they will be obliged to see more Medicaid patients who often do not cover the physician's cost of providing care. Others may be concerned that compliance with health reform's various provisions will increase their costs. Whatever the reason, health reform is viewed as an economic setback by the majority of physicians.

15) Health reform provides pilot projects to test "bundled (capitated) payments" for episodic care. What is your view of bundled payments?

A generally good idea	11%
A generally bad idea	68%
Unsure	21%

As referenced above, physicians direct 80% or more of healthcare dollars. Health reform includes provisions designed to encourage new quality/resource-driven payment models to reduce costs while maintaining quality. Bundled payments are encouraged by health reform through pilot projects intended to test their effectiveness in improving quality and reducing costs by aligning the interests of physicians and hospitals.

The majority of physicians, however, do not believe bundled payments are a good idea, while about one-fifth (21%) are unsure and may not be familiar with this reimbursement model. Only about one in ten physicians are positive about bundled payments, indicating that considerable education and persuasion will be needed in order to obtain physician buy-in for this and perhaps other emerging reimbursement models.

16) Which best described your attitude toward medical practice BEFORE reform was enacted?

Very positive	14%
Somewhat positive	37%
Somewhat negative	36%
Very negative	13%

Various physician surveys, including The Physicians Foundation's 2008 survey, reveal a growing amount of professional dissatisfaction among physicians, generated by a high level of regulation, declining reimbursement, rising malpractice costs and other so-called medical practice "hassle-factors."

Respondents to this survey were evenly divided on how they viewed medical practice prior to passage of health reform. Fifty-one percent said they were either "somewhat positive" or "very positive" about medical practice prior to reform, while 49% said they felt "somewhat negative" or "very negative" about medical practice prior to reform. Physician satisfaction has a direct effect on patient access to medical services. Low professional satisfaction and morale can lead to early physician retirement and other forms of work force attrition. That one-half of physicians already were negatively disposed towards medical practice prior to health reform suggests a widespread malaise in the medical profession that could lead to a reduced physician work force.

17) Which best describes your attitude toward medical practice now that reform has been enacted?

Very positive	6%
Somewhat positive	29%
Somewhat negative	33%
Very negative	32%

The survey suggests that physicians perceive health reform as further undercutting the medical practice environment. While 51% of physicians felt positively about medical practice prior to health reform, only 31% said they now feel positively about it. Less than half of physicians (49%) said they felt negatively about medical practice prior to health reform, while 65% now feel negatively about it.

18) Which is likely to have the greatest impact on your practice, health reform or a "fix" of Medicare's Sustainable Growth Rate (SGR) formula?

Health reform	34%
Sustainable Growth Formula (SGR)	36%
Unsure	30%

Though it makes sweeping changes, particularly to insure-related policy, health reform is not necessarily the primary policy item on physicians' agendas. Doctors also are concerned about Medicare's Sustainable Growth Rate formula (SGR) which mandates cuts to physician reimbursement to balance rising Medicare costs. These cuts have been repeatedly put off by Congress and in January, 2011 will reach approximately 30% if not addressed. Physicians are almost evenly divided over the relative importance of SGR and health reform to their practices, while 30% are unsure which will have the greatest impact.

19) Do you believe reform will compel you to CLOSE or SIGNIFICANTLY RESTRICT your practice to any category of patient?

Yes	60%
No	40%

The primary goal of health reform is to extend access to medical services to a broader segment of the population. How physicians view and react to reform will go a long way toward determining whether or not this goal is achieved. The survey suggests the majority of physicians believe they will be compelled by health reform to reduce access to their practices to one or more category of patients. Some patients, though insured, may therefore have difficulty accessing a physician.

Respondents to this survey were evenly divided on how they viewed medical practice prior to passage of health reform.

20) If yes to question 19, please indicate all that apply

	Close	Significantly Restrict
Medicaid	51%	42%
Medicare	30%	57%
Indigent	43%	38%
Patients covered through exchanges	24%	44%
Some HMO/managed care patients	17%	42%
All new patients	5%	37%
Self pay	10%	24%
Privately insured	3%	18%
Other	6%	9%

Health reform is expected to add 16 million people to the ranks of Medicaid enrollees at approximately the same time that some 75 million baby boomers will begin qualifying for Medicare benefits. The survey suggests that it is patients in these two government programs who may experience the most difficulty in accessing physicians. Of those physicians who believe health reform will compel them to limit access to their practices, 93% said they will either close or significantly restrict their practices to Medicaid patients. Eighty-seven percent said they will either close or significantly restrict their practices to Medicare patients. Some physicians indicated they will either close or significantly restrict their practices to virtually all categories of patient, including new patients, self-insured patients and privately insured patients.

Health reform is expected to add 16 million people to the ranks of Medicaid enrollees at approximately the same time that some 75 million baby boomers will begin qualifying for Medicare benefits.

21) Consider your practice plans over the next three years as reform is phasing in. Do you plan to (check all that apply):

Continue practicing as I am	26%
Cut back on hours	19%
Retire	16%
Switch to a cash or concierge practice	16%
Relocate to another practice/community	14%
Work locum tenens	14%
Cut back on patients seen	12%
Seek a non-clinical job within healthcare	12%
Seek a job/business unrelated to healthcare	12%
Seek employment with a hospital	11%
Work part-time (20 hours per week or less)	8%
Close my practice to new patients	6%
Other	4%

The majority of physicians surveyed (74%) said they will make one or more significant changes in their practices in the next one to three years, a time when many provisions of health reform will be phased in. Only 26% plan to continue practicing as they are. Most of the changes physicians indicate they will make will have the effect of reducing or eliminating patient access to their practices.

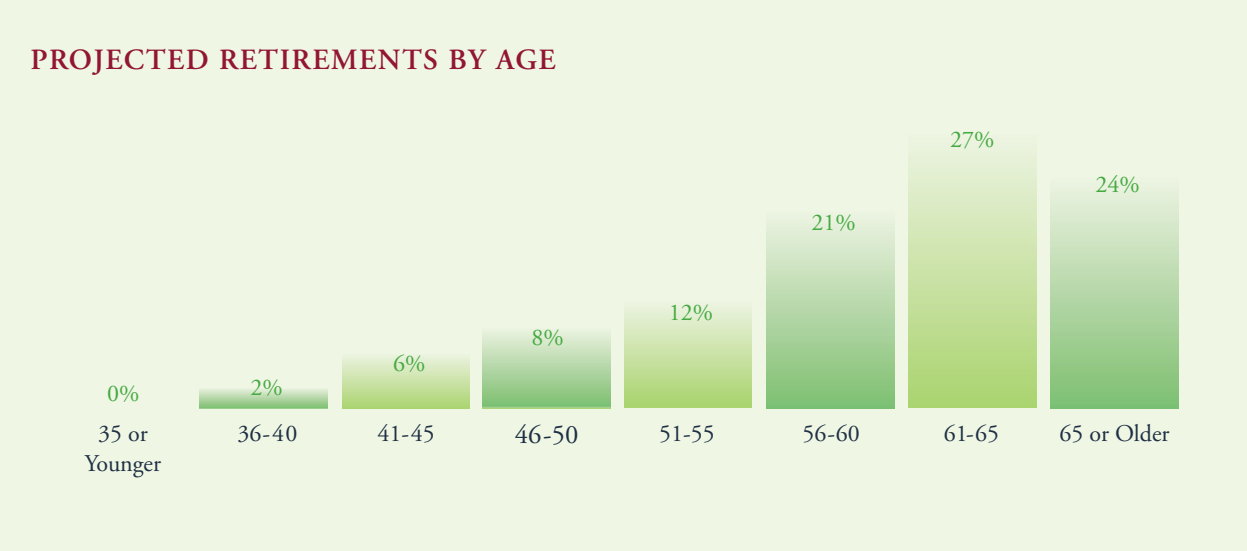
Forty percent of physicians said they will take one of three steps that would remove them from patient care roles altogether: they will retire, seek a non-clinical job in healthcare, or seek a job or business unrelated to healthcare.

Others plan to cut back on the number of patients they see, work part-time, close their practices to new patients or take other steps that would reduce their role as full time equivalents (FTEs) or limit patient access to their practices.

Close to half of physicians (49%) said they would adopt a style of practice different from the traditional, full-time independent private practice model: they will work part-time, work temporary (i.e., locum tenens) assignments, practice on a concierge basis, or seek employment with a hospital. This response underscores the increasingly heterogeneous nature of medical practice, in which niche practice styles are replacing the formerly prevalent full-time, independent practice model.

The implications of these findings are examined in more detail in the section of this White Paper entitled "Health Reform and the Physician Work Force."

The chart below shows the percent of physicians by age who indicated they plan to retire in the next one to three years:



The survey suggests that it is not just physicians in their sixties who plan to retire in the next several years. Twenty-one percent of physicians in their mid to late fifties, and 12% of physicians in their early to mid-fifties, indicated they plan to retire in the next one to three years. Even some physicians in their thirties and forties said they plan to retire in the next one to three years. Physician retirements at or even considerably below these rates would create severe disruptions in the physician workforce.

22) How do you believe reform will affect the independent, private practice model?

Will enhance the viability of the private practice model	10%
Will have little to no effect on the private practice model	10%
Will erode the viability of the private practice model	80%

Four out of five physicians surveyed believe that one of the consequences of health reform will be the erosion of traditional, independent private practice. Both the health reform law and market forces discussed elsewhere in this paper are driving a movement toward consolidation of physician practices and integration of practices with hospitals and other entities, eroding the viability of smaller, physician-owned practices.

23) Which best describes your view of the independent, private practice model?

It is a dinosaur soon to go extinct	28%
It is on shaky ground	58%
It is relatively robust and viable	14%

Over one-quarter of physicians (28%) see independent, private practice as being on its way out. The majority (58%) see private practice as unstable but not necessarily moribund. Only 14% view private practice as robust.

Four out of five physicians surveyed believe that one of the consequences of health reform will be the erosion of traditional, independent private practice.

ADDITIONAL INFORMATION

For additional information about this survey, contact Phillip Miller of Merritt Hawkins and AMN Healthcare at (469) 524-1400 or phil.miller@amnhealthcare.com.

Physicians on Reform

Physicians Reveal Their Thoughts on the Patient Protection and Affordable Care Act and on the State of Medical Practice in the United States

In addition to answering multiple choice questions, physicians completing the survey were asked to provide a written answer to the following question:

IF YOU COULD MAKE A STATEMENT TO POLICY MAKERS AND THE PUBLIC ABOUT HEALTH REFORM AND THE STATE OF MEDICAL PRACTICE TODAY FROM THE PHYSICIAN'S PERSPECTIVE, WHAT WOULD YOU SAY?

Following is a sample of over 1,200 comments contributed by physicians:

"I left private family medicine 3.5 years ago to join a private emergency medicine group. This change was prompted by the mountains of paper work/hassles imposed by the insurance industry. Health reform resolves none of the problems facing medicine today. It only changes a "monopoly" to a federally managed system. ***Jumping out of the frying pan into the fire."***

*"The most important issues affecting physicians were not addressed. One, physician reimbursement for primary care. If they really wanted to solve the problem of physician shortages the fixes in the plan are meaningless. Y****ou will never attract more grads with the poor pay!*** *Two, reform malpractice. It is killing medical practice."*

"Continue the move to ***universal, single payer healthcare!"***

"Healthcare reform ***penalizes the insured to cover the many uninsured*** *the many uninsured, some of whom choose to gamble and stay uninsured. There is no tort or vaccine/device malpractice reform and litigation and the fear of litigation continues to drive up costs and limit access. There also is no plan to reward or incentivize healthy choices and staying well."*

"I recommend basic government coverage for all (tax based). Additional insurance could be purchased for drugs and more expensive care. ***Yes, rich people will get better care but everyone will get good care,*** *like public and private schools. Tort reform has to happen."*

"If you think healthcare is expensive now, wait until it is free. ***All government run health plans fail.*** *Why would it work here? If you think it is so great, you should have the same plan."*

"The idea behind healthcare reform is good–basic care for all American's. The implications are very complicated from the standpoint of gearing up to meet demands. At some point, ***society will have to put limits on expectations*** *as to what is the appropriate healthcare that we can provide and pay for. Tort reform should be an integral part of all this."*

*"****Repeal it!*** *It is unsustainable and unaffordable."*

*"Regarding my outlook on the professional as a whole, l**et's just say my children are no longer considering medicine as their vocation.**"*

***"I am considering employment opportunities in the Peoples Republic of China.** Their medical system is less restrictive and appears to function in a free market, which I find tragically ironic."*

*My concern is the current under funding of Medicaid, along with the effect health reform will have on our growing deficit. **We should fix Medicare and Medicaid before taking on insuring more people.**"*

*"Tort reform has to be part and parcel of healthcare reform. **We can't have the Sword of Damocles** of malpractice suits hanging over our heads anymore."*

*"The government will take over healthcare as I retire and need medical care. **God help me!**"*

*"The **crisis will hit the fan** in four years when we will have thirty two million people who now have an insurance card and need to be seen."*

*"This **health reform law is a disaster**. We need to repeal this monstrosity of a law, the huge and unforeseen costs of this will surely bankrupt our country. We need true tort reform allowing health insurance to be bought across state lines and individuals the ability to purchase their own tax deductible health insurance to create competition and decrease healthcare costs."*

*"Why are we looking to this model that has f**ailed at the state level** and failed in Canada and other countries?*

*"I really don't know what to expect but I do not want the government running my practice or healthcare in general. Right now my medical practice is financially strong and serves the community. **I don't want to lose that!"***

"I have reached the place where I no longer care. Let the policy makers and insurance companies personally take care of the patients. They think they know best—let them have at it!"

*"I envision a **paperwork morass** soaking up a lot of money and making healthcare worse."*

*"The healthcare law is a **back door to a single payer system**. The healthcare law proponents use faulty data (U.S. mortality, number of uninsured) to scare the population."*

*"I wish all of the people who are standing in the way of reform could see how broken the system is and see how necessary reform is. **The reform act was fine but we need to go further**."*

*"Healthcare **is a right and not a privilege**."*

*"**I have taken care of the uninsured and the underinsured my whole career.** Making them " entitled" to my time and care feels worse than a slap in the face."*

"When a patient receives insurance who has been without it for years, he will bring a laundry list of

medical needs not projected in the debt this healthcare reform will create. ***Doctors aged 60-70 will retire,*** *increasing the shortage of doctors."*

"I find it unconscionable that in the "Christian nation" we have for so long ignored the basic health needs of so many citizens. ***Medicine is big business and should be anything but.*** *The government should insist on tort reform to lower costs in all aspects of medical care. Doctors should work under salaried contracts , as is the case in many premier centers (Mayo, Cleveland Clinics). We should engage the public in discussions of limits on expenditures, especially in Medicare settings but also in neonatology."*

"This bill is riddled with prohibitive regulations and disincentives. ***This is perhaps the worst piece of legislation I have ever seen.***

"Still ***very enthusiastic about healthcare reform,*** *but public option and tort reform should have been part of it."*

"Health reform will help lots of poor and middle class people in this country. ***Single payer would have been even better.****"*

"Health reform will fail without tort reform. ***The general public has no idea*** *how pervasive it is for doctors to order more and more complex exams to try and "CYA," and for people who don't care for themselves (i.e. smokers) to demand healthcare at the same price as those who eat right and exercise."*

"The state of medicine is in need of significant improvements, but ***a rushed sloppy policy*** *that does not include the input of physicians is akin to malpractice."*

"Politicians are missing the heart of the problem. There are ***not enough dollars in the system*** *to keep providing the care Americans want."*

"I trained in England and ***have seen socialized medicine first hand****. The care provided does not compare to what patients receive in the US. It is much lower. It is rationed care. In the future, if this terrible plan is not rescinded, our innovation will be stifled and quality of care will deteriorate. "*

"Like any other American citizen, ***physicians should be able to charge what they feel their services are worth.*** *If they overcharge, they will lose business. If they provide a good service at a fair price, they will gain business."*

"This reform will not only ***destroy the best medical care in the world,*** *it will decimate the insurance industry, pharmaceutical and medical device manufacturers and drive more American jobs to China and India and bankrupt this country."*

*"****We need a public insurance option*** *so everyone can afford to purchase coverage."*

"The era of Marcus Welby is over. *The idea of doing more for less is absurd.*
Only rationing fixes this mess."

"As an OB/GYN, malpractice together with extremely long hours is very tough. ***There will be very few doctors*** *going into these high risk specialties."*

*"Eventually, **there will not be enough doctors** to cover our needs nor will there be enough NPs or PAs."*

*"The current healthcare reform bill that was passed is a first step in improving the healthcare system in decades. It will also provide a shift in mentality to primary care which is a critical step to bringing down costs and improving health by prevention. **Remember, prevention is better than cure.**"*

*"**When private practice disappears,** the quality of medical care as well as access to it will decline dramatically."*

*"So much damage has already happened primarily in anticipation of change, including doctors 55 and older retiring and **many switching to concierge practices.**"*

*"I applaud the goal of insuring everyone that there needs to be more emphasis on promoting primary care or the system won't work. **Patients will not be able to find doctors.**"*

*"There will be fewer physicians and more patients so access to physicians will be rationed. Older physicians who are used to working longer hours than younger physicians will exit medicine. The cost/benefit for physicians to continue to work is no longer there. **Good luck recruiting new doctors.**"*

*"Why go to medical school and residency for 8-10 years after college, work hard, long hours, and come out with $250,000 in medical school debt, only to **not get paid enough to ever pay off those loans?**"*

*"How is this reform without tort reform? **Shame on the AMA for going along with this plan.**"*

*"The practice of medicine is one of the most time honored, sacred avocations known to man. The education and mastery of skill required is costly on a financial and personal level. To overload the system with more in need of care but not provide financial and practical incentives to meet their needs is unethical and **will have disastrous consequences.**"*

*"Primary care is at a crossroads. **Who will see all the new patients** who will have health insurance coverage? There are not enough primary care physicians available."*

*"**Do more for less,** with no limitation on liability, is not a sustainable approach."*

*"No one in the policy making world understands the problems physicians face. I wish they could **follow me through my practice** for one full week."*

*"Reform represents the **beginning of necessary change,** but much more needs to be done."*

*"Our opinion is the **last to be considered** though we make the system run. More consultation should be obtained from private practice M.D.'s and not tertiary care employed physicians!"*

*"There is **a limit to how far we can be pushed** and this is it!"*

*"It is so sad how the AMA sold us out and how this legislation was **rammed down our throats** against the will of the majority."*

"There is no way medicine will attract the kind of people we want to take care of our children and grandchildren. ***We can't owe $300,000 and make $80,000.****"*

"The private practice model will not be sustainable as the government dictates reimbursement rates. The end result will be ***a two-tiered system****. Concierge services for those who can afford it and a second rate system and delays in care for others."*

"This so called reform is the ***worst possible thing that could have been done****. Demand will increase, quality will decrease and people will begin to be treated not as customers but as demanding annoyances much as they are treated at the DMV."*

"I've ***already closed my practice*** *to Medicare/Medicaid patients."*

"Doctors are asked to see patients who are sicker and older with the expectations of care being higher and higher in an environment with decreased physician control, autonomy and respect. ***Why would anyone want to get into medicine now?****"*

"The health reform bill is the exact opposite of what should've been done. Return healthcare to the patient. Give the employee the money to purchase the insurance that meets his/her needs. When given the opportunity individuals can make rational choices. ***Please repeal this abomination.****"*

"We will have to see more patients in less time with increased paperwork and less reimbursement. ***I am upset and angry.****"*

*"****Solo private practice is doomed.*** *Small groups will follow then bigger groups."*

"The manner in which the ideologues in the Congress ran through this poorly conceived, duplicitous, unrealistic and incomplete plan was ***a travesty*** *which will exacerbate not improve our problem."*

I sympathize with the administration's goal of extending coverage to more Americans. However, coverage was already going to be extended due to the large number of baby boomers who will soon enter Medicare. I think it was foolish to further extend coverage without first fixing Medicare, which requires fixing SGR. So here we are ***floating toward a waterfall without a paddle.****"*

"All the people on the Titanic died when the large ship sank. Only the people in the small boats were able to float and carry on their legacy. Giving more power to insurance companies, large corporations and government cannot be the answer. In the future, we will have more bureaucrats, billers, coders, auditors and CEO's – ***but who is going to heal the sick?****"*

"The bill is too long and comprehensive to know what is coming. ***I fear the unknown.****"*

"Reform was too watered down. Without a public option there is no pressure for insurance companies to reform. It was a great idea but the political process ***deformed it into a placebo.****"*

*"****Healthcare is a right,*** *not a privilege. If this hurts the economic success of medicine as a business, that is a necessary event."*

"The AMA has totally failed primary care private practitioners - and I am a former Delegate! ***We have zero representation*** *by AMA or ACP, which are way overloaded with academics who are clueless about private practice. Primary care doctors pay tens of thousands of dollars a year to send their expense records to people who get paid to analyze "quality" (as they call it). This is a huge and worsening whole in the side of a boat; not just the annoyance, the actual dollar costs are killing us financially."*

"Physicians have not done enough pushing back against the misguided policies proposed in D.C. ***We are too busy taking care of patients!*** *MD's should start running for state and local offices to get a bigger voice in government."*

"Health reform will decrease access to care for patients as it will ***drive doctors to retire early*** *or leave medicine altogether at a young age."*

"We need more primary care residency slots to serve the newly insured. Also, all of the children should be insured. ***What kind of country doesn't to that?****"*

"There must be more awareness of the price of services in the patients mind and there must also be ***more responsibility place on the patient*** *to pay more directly for services. This way the competition will drive prices down."*

"Other professionals can unionize and push for more rights whereas physicians have to sit by and allow ourselves to ***accept what is handed down from our government.*** *Claiming physicians support based on AMA support is unsustainable as the AMA is not supported by at least 75% of physicians."*

"Politicians should consider the ramifications of their actions on the medical community. If they fail to consider how physicians can deliver the best care, there will be no viable future for any plan. Physicians should be prime contributors to the debate, ***not just children*** *who will be handed decisions to afterwards.*

"It would be nice to have a "regular Joe" type of MD in policy making. ***They forgot us*** *– those who struggle in the trenches daily and have to pay exorbitant amounts to become "electronic".*

"I see an absolute crisis on the horizon. ***Obamacare is the Titanic****".*

"Health reform is necessary. We must cover all patients regardless of the ability to pay. The system we have now is immoral. Reform should've gone further, gotten rid of insurance companies and given us ***a single payer option.****"*

"Healthcare is a ***benefit of modern society, but not a right.*** *Certain health issues such as immunizations may fall into the public's best interest and therefore may be electively provided by the state. Otherwise, the key to individual healthcare is portability beyond employment, individual responsibility and incentive-based rewarding of those taking responsibility for their own care."*

"I am two years out into cardiology practice and my group is being forced to sell its autonomy and the practice to survive. We are ***desperate about the future*** *and what it holds for medicine in the U.S. – including the impact on patient care and access."*

"From my perspective reform was absolutely necessary. The way healthcare has been progressing was not sustainable. I think the general public needs to have a better understanding of the reasons these things are happening and to ***bear some responsibility*** *in this whole process including reasonable expectations and appropriately utilizing services."*

"Reform is a ***major step in the right direction*** *but needs to have more revisions over time, including leveling of payments for cognitive specialties vs. procedural specialties."*

"I have been in practice for fifteen years. The last six, I have spent in a clinic caring for uninsured, indigent and low income patients. I spend more and more time doing paperwork, record keeping, getting prior authorizations on tests, drugs and equipment and less time actually giving care. ***I have had it and I'm leaving primary care.****"*

"Restore the value of our services. Quality will suffer if I am replaced by practitioners. If NP's are given the right to practice independently, ***my degree will be worthless.****"*

"As a primary care physician, health reform will help my uninsured patients. It will help me by having a method of payment for things ***we now provide for free.****"*

"The US has the best medical system and most advanced care in the world. Every physician I know will ***gladly take care of the uninsured*** *if you eliminate the liability. Who wants to do work for free and then be sued for millions of dollars. Tort reform will provide a tremendous cost savings by lessening defensive medicine."*

"Health reform is so complex that is almost ***impossible for any one person to understand.*** *Physicians will not leave medicine because of decreased income. They will leave because of increased regulation and lack of gratefulness from patients when healthcare is seen as a right and not a privilege."*

"Liability reform is a must. We all live under a cloud of malpractice lawsuit threats. The number of challenges in private practice make it ***less likely that I will be in practice in the next 5-10 years.****"*

ADDITIONAL INFORMATION

For additional physician comments see the book:
In Their Own Words: 12,000 Physicians Reveal Their Thought on Medical Practice in America
www.amazon.com

Compliance Issues and Physician Practices

The Patient Protection and Affordable Care Act ("ACA") and other recent amendments to existing laws present a host of compliance issues for physician practices. The federal government is stepping up enforcement of healthcare laws, giving these compliance efforts even greater urgency. As evidence of the Government's intent to focus on compliance, the ACA has allocated an additional $350 million through 2020 to fight healthcare fraud and abuse. In addition, payments for care may now be suspended by CMS during investigations of "credible allegations of fraud," with the definitions of a "credible allegation" to be determined by the Department of Health and Human Services ("HHS"). Significant changes are made in the ACA to existing criminal and civil enforcement provisions that remove or substantially weaken historically available defenses; other provision are designed to create transparency in manufacturer-provider and other relationships.

Jane Jordan, Chief Health Counsel at Emory University in Atlanta and a member of the Advisory Panel for this White Paper, advises practices—no matter their size—to create and implement their own compliance plans as a major way to address these changes in the law and increased government enforcement initiatives. Although physician practices are not currently required to have such plans, Jordan thinks they will eventually become mandatory as HHS creates a list of providers that must adhere to such a requirement. "It's just a matter of time before you must have a formal plan; good practice and common sense mandate that you do so now," she says. If practices do not implement compliance plans and follow them strictly, they will put themselves at a huge risk.

Guidance for such plans was issued in 2000 by the Office of the Inspector General in connection with the passage of the federal sentencing guidelines: under those guidelines, if a party had an effective compliance plan in place in the event of a conviction of a crime, the court could reduce the sentence of the convicted party[1]. At that time, the OIG stated that in order for a compliance plan to be effective for reduced sentencing, all entities, including physician practices, as part of their compliance plans, must:

- Conduct internal monitoring and auditing
- Implement compliance and practice standards
- Designate a compliance officer or contact
- Conduct appropriate training and education
- Respond appropriately to detected offenses and develop corrective action
- Develop open lines of communication and enforce disciplinary standards through well-publicized guidelines

While the OIG stated in 2000 that it did not expect smaller companies (including physician practices) to implement all of these components, the list could help practices that were evaluating areas in which they were at risk for government enforcement so their plans could be drafted accordingly. In today's environment of increased enforcement, these guidelines become even more critical as practices evaluate the need to implement their own compliance programs.

A further aspect of an effective compliance plan is the interplay with good human resource practices, which will be more important than ever, as whistleblowers now have access to more legal avenues for reporting suspected violations of fraud and abuse and other laws. The ACA now allows individuals to use public information—even news reports—as the evidentiary support for an allegation, a new twist to the laws governing the basis for a whistleblower suit. Among other things, human resource policies must provide would-be whistleblowers with a safe place to report a troubling occurrence, and a clear and objective process to address that occurrence. Jordan noted that most whistleblowers are not primarily seeking monetary rewards, but are truly troubled about billing or other matters at their organizations and want to see those issues resolved. "You always want this person to have his or her concerns addressed," said Jordan, "without fear of reprisals." Indeed, practices must understand that an employee has a legal right to bring compliance issues to the attention of his or her employer without fear of termination.

Transparency

Since the advent of the Sarbanes-Oxley law in the early part of the decade following the Enron and other similar crises in large publicly held companies, transparency in the financial practices of corporations has become a mandate. The new ACA now adopts that focus on transparency in certain changes to portions of the Stark Law as well as new "sunshine" provisions regarding disclosure of physicians' financial relationships with industry. For example, practices now must give written notice to patients about the ownership of in-office ancillaries and give patients a list of local alternatives when referring them to an ancillary's service or product. "Practices need to demonstrate that they have given patients a choice," said Jordan.

Another change to existing laws are that following the development of policies and procedures by HHS, physician owners or investors in hospitals will have to disclose their ownership to their patients referred to the hospital, in addition to including this fact on the hospital's web site and in any of the hospital's advertisements. Additionally, hospitals must tell patients prior to admission if it does not have a physician on premises during all hours in which the hospital will provide services to the patient. For both of these requirements, HHS will implement policies and procedures within eighteen months of the ACA's enactment. At that time, these disclosure requirements will begin.

Also in the next few years, both pharmaceutical firms and medical device manufacturers will be required to report to HHS their financial relationships with doctors. This requirement goes into effect in March, 2013, for payments (subject to some exclusions, including product samples, educational materials that directly benefit patients and permitted discounts and rebates) that were made in 2012. Many device manufactures and pharmaceutical companies are already making this information publicly available on their web sites, following several instances of non-disclosure to research universities by employed physicians of their payments for outside consulting services. Jordan recommends that physicians follow the lead of the pharmaceutical companies and device manufacturers and take preemptive action to make this information public now, again in the interest of total transparency. She noted that physicians would not want patients to learn from another source about a financial relationship and wonder, "Why didn't my physician tell me?" Jordan pointed to numerous physician practices already taking these steps.

The Cleveland Clinic, for instance, details on its web site the financial relationships of individual doctors who serve as consultants for firms or are participating in a drug trial, and details the amount of payments on an annual basis. Jordan predicts that eventually these "sunshine" provisions in the ACA will apply directly to physicians. "The clear trend is toward total transparency in financial relationships," she said.

Changing Legal Standards Affecting Physician Relationships and Payments

The ACA has limited certain ownership options currently available for doctors and also created harsher standards for laws regarding disclosure of financial relationships and discovery of possible overpayment.

Physician Ownership In Hospitals

First, physician ownership of hospitals has been severely limited. While previously doctors could invest in whole hospitals under the "whole hospital" exception under the fraud and abuse laws, such arrangements formed after this year will be ineligible to receive Medicare and Medicaid payments. Existing hospitals that are wholly-owned by the doctors who invest—numbering 265 nationwide[2]—will be grandfathered in only if they have a provider agreement with Medicare by December 31, 2010.

Furthermore, hospitals cannot increase the percent of physician ownership. Going forward, only under limited circumstances will these hospitals be able to add beds and operating rooms. While this aspect of the ACA faces at least one legal challenge filed in June, 2010, the measure is already in effect, since the ban on expansion started March 23, 2010. Physician Hospitals of America (PHA), Sioux Falls, South Dakota, is one of the plaintiffs in the suit. The organization argues that preventing the expansion and opening of new hospitals will hurt access to care and hamper competition. It further argues that these hospitals provide jobs and tax revenues to communities, noting that these hospitals employ more than 75,000 full and part-time employees and have an average yearly payroll of $13 million, with $3.4 billion in a total annual payroll nationally.[3] It is likely that similar lawsuits will be filed with respect to other aspects of the ACA, and indeed, there are numerous states which have or are in the process of filing suits to challenge the constitutionality of the ACA itself. The likelihood of success of any of these lawsuits is impossible to predict, and even an ultimately successful result would be years in the making as the cases wind their way through the judicial process.

The critics of physician-owned specialty hospitals have charged that the facilities "cherry pick" patients, treating only those that are not severely ill, because they create a greater financial reward. Some evidence supports this claim.[4] Critics also say that these hospitals treat low numbers—if any—patients who are uninsured or underinsured.

The ACA also freezes physician investment in hospitals as of March 23, 2010. Therefore, if a hospital has a new physician investor, another physician must sell his or her interest or all physicians must reduce their percentage of ownership. This could be difficult if each physician owner has only a 2 percent investment, which was the average found in a GAO study of physician ownership of specialty hospitals.[5]

PHYSICIAN-OWNED HOSPITALS

Multispecialty

Actual Number 149
Average Staffed Beds..... 40

General Acute

Actual Number 54
Average Staffed Beds.... 233

Heart

Actual Number 18
Average Staffed Beds..... 65

Orthopedic

Actual Number 18
Average Staffed Beds..... 24

Rehabilitation

Actual Number 12
Average Staffed Beds..... 34

Long Term Acute Care

Actual Number 8
Average Staffed Beds..... 30

Emergency Care

Actual Number 3
Heart and General Acute ...1
Multispecialty Children's....1
Multispecialty Women's 1

Source: Silva, P. Physician-owned hospitals: Endangered Species?" American Medical News. June 28, 2010.

New Deadlines for Overpayments

Another aspect of the ACA that is already in effect (as of May 22, 2010) but which has not received wide attention is critically important in terms of compliance with respect to payments from CMS. Prior to the ACA, a "false statement" was required to prove a violation of the False Claims Act, one of the most serious fraud and abuse acts to which physicians and providers are subject. Under the ACA, "knowing" and "improper" concealment or simple avoidance of an obligation is sufficient and represents a critical change in the applicability of the law. Previously, physicians and other providers did not have a time deadline to determine if an "overpayment" had occurred and if a repayment was due to CMS; there was time, for example, to carefully evaluate a bill and conduct an audit or other confirmatory process to determine if in fact an overpayment had occurred and the amount that the payment should be. Now physician practices have a 60-day deadline "after the date on which the overpayment was identified OR the date any corresponding cost report is due, if applicable" for reporting and returning overpayments. This part of the ACA also does not define the term "identified," leaving physicians unsure in some cases when the countdown to the deadline begins. Because of the vague wording, identification could be when overpayment is strongly suspected or when it is actually quantified. Interestingly, CMS had proposed a 60-day deadline for overpayment returns previously, in 1998 and 2002, but did not continue efforts to finalize the requirement because of widespread criticism.[6]

In addition, the new law creates an "obligation" under the False Claims Act for failure to report and return the overpayment. Doctor practices that have delays in returning identified overpayments would be liable for potential prosecution under the False Claims Act; If successfully prosecuted, practices could pay treble damages and fines for each claim. While the measure has already taken affect, the yet-unpublished regulations will be key in determining how strictly this new measure will be applied.

"Intent" No Longer a Factor in Anti-Kickback Statute

An important but often overlooked change in the Anti-Kickback Statute (the criminal statute that applies to all relationships where referrals of business occur from one healthcare entity to another) now makes it easier for a physician to run afoul of the law. Prior to the ACA, a key requirement for prosecution was to demonstrate that an individual (or entity) had to have actual knowledge that an arrangement was violating the law or that he or she had specific intent to violate the law. That aspect of the Anti-Kickback Statute, and key defense, has been removed. "These lower thresholds will make it easier for the government to indict and convict the alleged violators," said Jordan. In addition, the statute was amended to make an Anti-Kickback violation a false or fraudulent claim under the False Claims Act, creating a second avenue for prosecution. Lastly, the sentencing guidelines for persons convicted of healthcare offenses related to federal healthcare programs when the loss involves more than $1 million will have increased offense levels.

Other Important Changes

The Recovery Audit Contractor ("RAC") program, in which third party auditors look for improper provider payments and can retain 9 percent to 12.5 percent of what they recover, will be expanded to Medicare Part C, Medicare Advantage Plans, and Part D, prescription drug coverage. Jordan warns that the broad powers afforded to the RAC auditors could be dangerous: for example, a RAC settlement for improper payment does not necessarily negate liability under the False Claims Act, so practices could be possibly prosecuted under that statute after paying a settlement, a kind of "double jeopardy," says Jordan.

In addition, the healthcare reform law encourages states to pass their own Stark laws, and physicians need to be aware of state statutes that place limitations on financial arrangements between practices and vendors. In some states that already have these "Baby Stark" laws in place, the prohibitions on physician relationships with referral sources can often be harsher than the federal statute, and should be carefully monitored.

Although not in the new reform law, another recent development demands the attention of physician practices. In 2009, the privacy requirements of the Health Insurance and Patient Affordability Accountability Act ("HIPAA") that applied to physician practices were amended to extend to a practice's business associates. The HIPAA requirements have also been expanded and extended under the recent Health Information and Technology Act ("HITECH") Jordan recommends that if practices use intermediaries for billing or other functions, or deal with any third party in any way that involves the use of patient health information, that the practice carefully document the relationship with that business associate and update the contract to account for the new changes. One potential provision that could assist practices greatly (although it will likely be resisted by the vendors) is to include an indemnification provision whereby the vendor indemnifies the practice for any action on the part of the vendor/intermediary that might violate HIPAA.

Although not part of the ACA as a new enforcement initiative, Jordan had one other word of precaution and advice regarding preventive steps that a physician practice can take—the use of electronic medical records, which was recognized as a necessary step on the future of healthcare and funding made part of the federal stimulus bill. Jordan believes that physicians without electronic medical records (EMR) will be more at risk for a medical malpractice suit if most providers in their market have an EMR. The law has long recognized the standard of "reasonable care" in a particular

community, and that standard now includes an EMR in many metropolitan areas. Jordan presents a scenario in which a patient is injured because a pharmacist or nurse couldn't read a doctor's handwriting, or a patient's allergies were unknown due to paper charting that omitted the information.

"With all the emphasis on IT, an EMR is becoming an assumption and a 'must have', not something that's 'nice to have,'" she said.

Lastly, practices need to make sure they are following all provisions of the ACA as employers, such as the requirement that the health plans they offer contain the extension of dependent care for children under age 26 and a removal of lifetime caps on coverage. Practices can check to see if they are qualified be to a "grandfathered" plan which will allow them more flexibility in structuring their health plans. Also importantly, practices will want to look at how these changes will impact their health insurance cost.

Recent Developments/New Self-Disclosure Process for Stark Violations

On September 23, 2010, CMS released its long awaited self-disclosure protocol for physician self-referral prohibitions, as required by the ACA. Entities that discover even inadvertent Stark noncompliance often have no good options. Repayment of prohibited claims can be unaffordable, but failure to repay can expose an entity to False Claims Act liability and attendant qui tam suits. Moreover, with very few exceptions, negotiated settlement has not been an option: the HHS OIG's self-disclosure protocol is no longer available for Stark violations, and, until now, CMS has provided no similar avenue for redress.

Now the OIG has issued a Self Referral Disclosure Protocol ("SRDP") that provides a framework for physician practices to self-disclose actual or potential violations of the Stark Law. Consistent with similar frameworks developed by the OIG, disclosure is required within 60 days after an "overpayment was identified." The SRDP states that parties generally may not make repayments while a self-disclosure is pending, but that timely disclosure will suspend the 60-day period during which parties otherwise are required to repay overpayments under PPACA. Among other things, the SRDP provides that the disclosure must include a "description of the existence and adequacy of a pre-existing compliance program," which adds to the importance of implementing effective compliance programs as part of a physician practice's compliance effort.

The disclosure must identify the total amount "due and owing" from the entire period "during which the disclosing party may not have been in compliance with the physician self-referral law." Importantly, the ACA authorizes the OIG to reduce parties' repayment obligations under Stark. CMS did not, however, set a stipulated penalty for technical noncompliance. A self-disclosing party therefore will not know at the outset of the process whether self-disclosure will result in a reduced repayment obligation. Factors that CMS has said it will consider in determining the repayment amount include:

- The nature and extent of the violation
- The timeliness of self-disclosure (in practice, because self-disclosure must be made within 60 days of discovery, this likely refers to the timeliness of discovery)
- The disclosing party's cooperation
- Litigation risk
- The disclosing party's financial condition

While the SRDP did not provide as much relief as initially hoped when the ACA was first passed, there is now at least a process for self-disclosure and possible reduction in Stark penalties. "It's likely that practices will have to pay something," said Jordan, "but at least they can get resolution of their situation." In any event, availability of the process significantly changes the calculus as to how parties should address Stark noncompliance, and continues the increased pressure—including that arising from the recent changes to the False Claims Act—to have in place effective preventive and compliance mechanisms.

Ten Things to Remember

1) Whistleblowers will have relaxed standards for reporting
2) Providers must, within 60 days of identifying a Medicare or Medicaid overpayment, report and return it
3) The Anti-Kickback Statute no longer uses intent for or knowledge of law violation as a standard in judging whether an individual has broken of the law
4) Doctors making referrals to in-office ancillaries must now give patients information about the ownership and a list of alternative providers
5) Doctors must tell patients of the physicians' ownership interest in a hospital, if patients are referred there
6) Doctors now have a self-disclosure process available to them under the Stark law, and an HHS representative will have the authority to settle the matter
7) States may pass their own versions of the Stark law (and some already have)
8) The Recovery Audit Contract program now will be used with Medicare Parts C and D
9) Practices should check that the health and other benefit plans they offer employees comply with the healthcare reform law
10) Proof of compliance is key: have a good and effective compliance program in place

1. Federal Register. Vol. 65. No. 194, p. 56434.
2. Physician Hospitals of America. "Federal Lawsuit and Injunction Filed Challenging Limitations on Physician Owned Hospitals in Healthcare Reform." June 3, 2010. www.physicianhospitals.org/documents/PHATSJHPressRelease060310.pdf
3. Ibid.
4. GAO Report. Specialty Hospitals: Information on National Market Share, Physician Ownership and Patients Served. GAO-03-683R, April 18, 2003.
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6. Freemire, JJ. New 60-Day Time Limits for Reporting and Returning Overpayments. Health Care Legislation Update–Issue 1. April 26, 2010. Ober Kaler. www.ober.com/publications/264-health-care-legislation-update–issue-print

Health Reform and the Physician Work Force

Supply, Demand and Access

Introduction

During the next decade, health reform will extend medical coverage to over 30 million people. Whether or not coverage will equate to access to physician services, however, is another question. The answer will depend on the ability and willingness of the physician work force to accommodate both the newly insured and the rest of the nation's growing and aging population.

In this section, the Panel examines the physician workforce implications of health reform, including:

- Provisions in the law affecting the physician work force
- A key omission in the law
- Primary care/specialist disparities
- Physician distribution
- Demand for physician services
- Medicare/Medicaid patient access to physicians
- Emergency department utilization
- The medical practice environment
- Physician practice patterns

Summary of Findings

It is the Panel's position that health reform will, on balance, contribute to a growing shortage of physicians, and that patients in a variety of categories, including those enrolled in Medicare and Medicaid, will find it increasingly difficult to access physician services in a timely manner. Reform will create significant additional demand for physician services but will not create enough new physicians to meet existing and emerging demand.

Physicians will have to rethink their roles and adjust their practice patterns to accommodate the increased demand health reform will generate, as well as to meet the demands of a growing and aging population.

Though reform includes provisions many physicians may find attractive, it does not address areas of primary concern to physicians, including a fix of the Sustainable Growth Rate (SGR) formula and tort reform. It does, however, include provisions likely to further disengage physicians from medical practice and thereby reduce the physician workforce. The basic conditions of today's medical practice environment, which many physicians find increasingly untenable, are not appreciably changed by reform. These conditions should be addressed in order to preserve an engaged physician work force capable of retaining practicing physicians, attracting new entrants to the field and addressing the healthcare needs of a growing and diverse nation.

Work Force Provisions in the Patient Protection and Affordable Care Act

Expanding access to healthcare cannot be accomplished merely by providing health insurance to a greater number of people.

As a practical matter, health insurance is of little value if physicians or other clinicians are not ready, willing and able to see patients in a timely manner.

This point was not lost in the run-up to health reform. Over the last several years, numerous organizations have warned of a growing shortage of physicians in the United States and of the need to train more doctors. The Association of American Medical Colleges (AAMC) forecasts that in 15 years the United States will face a deficit of up to 159,300 physicians, over one-third of them in primary care.[1] The AAMC projects that universal access would increase the physician shortage by an additional 31,000 doctors.

The American Academy of Family Physicians (AAFP) projects a shortage of 149,000 physicians by 2020,[2] and the Health Resources and Services Administration (HRSA) projects a shortage of 65,560 primary care physicians by the same year.[3] Twenty-four states and 21 medical societies have projected physician shortages.[4] Both the AAMC and The Council on Physician and Nurse Supply, a group of healthcare experts co-chaired by Richard Cooper, M.D. and Linda Aiken, Ph.D. of the University of Pennsylvania, have called for a 30% increase in the number of physicians trained in the United States.[5]

The Patient Protection and Affordable Care Act ("health reform") both expands access to health insurance and includes provisions (direct and indirect) designed to increase the supply of physicians, nurses and other clinicians to accommodate the newly insured, the traditionally underserved and others. Among various workforce provisions, the law:

1) Establishes a national Workforce Advisory Commission to coordinate and implement work force planning and analysis. Members of the Commission are to be appointed by September 30, 2010. The Commission must submit to Congress and the Administration (starting in 2011) an annual report showing current healthcare work force supply and demand projections, implications of Federal policy affecting the work force and make various recommendations.
2) Establishes a National Center for Health Workforce Analysis within the Department of Health and Human Services (HHS) and authorizes grants for state and regional Centers to collect, analyze and report data and to develop ways to increase the supply of primary care physicians.
3) Redistributes unused Medicare-funded residency slots to teaching facilities that agree to train more primary care physicians and general surgeons (effective July 1, 2011). Preference will be given to training programs in states with the lowest resident physician-to-population ratios.
4) Allocates $1.5 billion over five years (2011–2015) to expand the National Health Service Corps (NHSC) which repays school loans and offers scholarships to primary care providers who agree to work in medically underserved area. The maximum annual loan repayment available to Corps members increases from $35,000 to $50,000 under the law and Corps members can satisfy their service obligation through part-time clinical practice (a minimum

of 20 hours per week.) Corps members based at Teaching Health Centers (see below) are allowed to count up to 50% of their time spent teaching towards their full-time service obligation. The funding is projected to direct 15,000 primary care providers to medically underserved areas.

5) Establishes Teaching Health Centers (THCs), defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally funded health centers that are eligible for Medicare payments of the expenses associated with operating primary care residency programs (initial appropriations scheduled for fiscal year 2010.) Appropriates up to $230 million for fiscal years 2011–2015 for direct and indirect costs of training residents for qualified THCs.

6) Dedicates $250 million from a public health fund established by the law to help produce 16,000 new primary care providers (physicians, physician assistants and nurse practitioners) by 2015. HHS will allocate the funding through the law's $500 million Prevention and Public Health Fund. $168 million will be allocated to increase primary care residency slots, with a goal of training 500 new primary care physicians over the next five years. $32 million will be dedicated to support primary care training for more than 600 physician assistants, $30 million will be dedicated to allowing more than 600 nursing students to enroll in full-time training programs, $15 million will be dedicated to funding 10 nurse-managed health centers to train nurse practitioners, and $5 million in grants will be allotted to states to implement "innovative strategies" to expand the primary care workforce.

7) Offers increased flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010) and ensures the availability of residency programs in rural and underserved areas.

8) Increases workforce supply and support training of health professionals through scholarships and loans; supports primary care training and capacity building; provides state grants to providers in medically underserved areas and supports the development of mental and behavioral health training programs.

9) Addresses the projected shortage of nurses by increasing the capacity for education, providing loan repayment and retention grants, and creating a career ladder to nursing.

10) Provides grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics (funds to be appropriated for five years beginning in fiscal year 2011).

11) Provides a 10% Medicare pay bonus to qualified primary care physicians. In addition, general surgeons who practice in federally designated Health Professional Shortage Areas (HPSAs) will qualify for a 10% Medicare pay bonus from 2011–2015 for performing certain procedures.

12) Increases Medicaid payments to primary care physicians to Medicare levels for 2013 and 2014.

A Critical Omission

Despite these provisions, health reform may be more conspicuous for what it does not do to address doctor deficits than for what it does. Due to an omission in the bill, shortages of primary care physicians and many specialists are likely to persist over the next ten to 15 years and may become even more problematic.

Shortages of physicians will continue because health reform does not address the key factor inhibiting physician supply in the United States—a cap on funding the federal government provides for physician training.

As part of the Balanced Budget Act, Congress in 1997 put a cap on funds Medicare spends to train physicians at the nation's teaching hospitals. Medicare allocates $9.5 billion annually to teaching facilities in support of physician graduate medical education (GME), helping to fund the training of over 100,000 residents.[6] In 2009, Medicare provided direct payments of $3 billion to teaching hospitals to cover a portion of resident salaries and other allowable expenses and $6.5 billion as an indirect medical education adjustment to cover the added costs of patient care in teaching facilities, which often see the sickest and most expensive to treat patients, many of them uninsured.[7] Although major teaching hospitals account for only six percent of all acute care hospitals, they provide 22% of services to Medicare beneficiaries, 28% of all Medicaid care and 41% of all hospital based charity care in the nation.[8]

Various states also provide funding for GME through the Medicaid program, but these funds are dwindling. As noted by the New England Journal of Medicine, "In 2005, 47 states provided a total support of $3.78 billion through their Medicaid programs: by 2009, only 41 states were providing $3.18 billion in such support, and nine additional states reported they had considered ending their payments to teaching hospitals."[9]

With state and private funding sources limited, the number of physicians trained in the U.S. can only be significantly increased if the Medicare GME spending cap is removed.

With the cap in place, the number of physicians being trained in the United States lags far behind population growth. The number of residents and fellows trained in the U.S. grew by only 8% from 1987 to 2007 while the population grew by 24%, from 242 million people to 302 million.[10]

Prior to the passage of health reform, various law makers introduced legislation intended to remove the cap and increase the number of residents being trained. On May 8, 2009, Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) introduced the Resident Physician Shortage Reduction Act, which would have increased residency slots by 15% in order to add 15,000 additional residents to the work force. In support of the Act, Senator Schumer stated, "No health reform effort will be complete or even adequate unless we address the shortage of doctors in this country."[11]

To that end, the Act called for redistribution of unused residency slots, with preference given to primary care training slots and to states with low resident-to-population ratios. The states with the lowest resident-to-population ratios, and those most likely to have benefited from the Act, are Montana, Idaho, Alaska, Wyoming, Nevada, South Dakota, North Dakota, Mississippi, Florida, Indiana, Arizona, and Georgia. Though health reform also includes a provision to redistribute residency slots, the new law does not go nearly as far as the proposed Act to increase overall residency positions.

The redistribution of unused residency slots mandated by health reform will increase the number of physicians trained in the U.S., but only marginally. In 2009, 121,000 residency slots were available nationwide, of which 106,000 were used.[12] Residency slots may go unused in given years due to lack of faculty, infrastructure, funding or other reasons. However, Congress was only prepared to redistribute some 900 unused residency slots through health reform, at least 75% of which must be devoted to primary care or general surgery.[13] This will lead to an increase of only several hundred graduating residents per year, far short of the thousands AAMC and other organizations believe are needed. The 500 additional primary care physicians that HHS has allocated $168 million to train also will have a minimal impact on overall physician supply. Furthermore, health reform includes Medicare reimbursement cuts to Disproportionate Share Hospitals, which could inhibit their ability to maintain residency programs.

The supply bottleneck at the residency level undercuts the effect that producing more medical school graduates will have on the physician work force. Not a single allopathic medical school opened in the United States in the 1980s and 1990s. However, due to initiatives spearheaded by AAMC, over a dozen allopathic medical schools have started the accreditation process since 2007 and five osteopathic medical schools have opened.[15]

The nation now is on track to produce 30% more medical school graduates by 2015, in line with AAMC's goal:

MEDICAL SCHOOL NEW ENROLLEES

Allopathic Medical Schools		Osteopathic Medical Schools	
2002	16,488	2002	3,079
2009	18,390	2009	5,104
2014	20,281	2014	6,271
	(23% Increase)		(103% Increase)

Source: Silva, P. Physician-owned hospitals: Endangered Species?" American Medical News. June 28, 2010.

However, unless residency slots increase proportionately, new U.S. medical school graduates will only replace international medical school graduates (IMGs) at the nation's residency programs. Graduates of international medical schools now comprise about 7,000 of the 25,000 residents and fellows who complete their training each year. Reducing our reliance on IMGs may be prudent at a time when physicians from countries such as India and China can find more opportunities at home, but doing so will not increase the net number of doctors trained or practicing in the United States.

Increasing the number of residents who complete their training each year by several thousand rather than several hundred would require Medicare to spend approximately $3 billion more on GME annually than it does now. These funds could only become available if the cap on such funding is removed, a step that would literally require an Act of Congress. Though a considerable sum, $3 billion represents one third of one percent of the Department of Health and Human Services' (HHS) $910 billion budget for

fiscal year 2011, and less than one percent of Medicare's $464 billion budget for FY 2010.[16] Nevertheless, the extra expense was seen as a political liability to Democrats seeking to keep the cost of health reform below $1 trillion. In addition, during a recession, few politicians are willing to support spending additional sums of money to train physicians, who are popularly perceived to be high income earners.

A further impediment to removing the cap is that not all policy experts and academics are convinced that the federal government should be allocating more funds to train additional physicians. Researchers at the Center for Health Policy Research at the Dartmouth Institute for Health Policy and Clinical Practice, who produce the widely referenced Dartmouth Atlas of Healthcare, have gone on record challenging the notion of a physician shortage. David Goodman, M.D., director of the Center for Health Policy Research, was quoted by Los Angeles Times as follows, "I don't think there is an overall doctor shortage and I don't think we are facing one."[17]

Dr. Goodman and other analysts at the Dartmouth Institute for Health Policy and Clinical Practice have argued that the number of physicians in a service area is not related to quality of outcomes achieved and that a relatively large number of physicians per population often is associated with both poor outcomes and higher costs. They contend that physicians in the Upper Midwest provide consistently better and cheaper care than their counterparts in big cities, even though the number of physicians per population is typically higher in large cities than in the Upper Midwest. They further argue that if physicians in large urban areas and some areas of the South would practice more like physicians in Minnesota and other states in the Upper Midwest, quality could be improved and costs reduced.

Dartmouth's position that the United States should only train a small number of additional physicians in order to suppress costs and improve quality is now in wide dispute[18] and is not subscribed to by the Advisory Panel. Nevertheless, this view prevailed in the health reform law. Provisions in the law will increase the number of physicians completing residency training each year, but only by a few hundred. This will not be enough to meet the nation's needs.

Effect on Primary Care/Specialist Disparities

There are additional factors beyond the residency bottleneck that will contribute to persistent physician shortages in the United States. These factors are addressed by healthcare reform, but not in ways likely to eliminate or even significantly reduce shortages.

The doctor shortage is particularly acute in primary care (family practice, general internal medicine, pediatrics) in part because the number of U.S. medical graduates choosing to enter primary care has declined in recent years. Between 2002 and 2007, the number of U.S. medical graduates choosing to become family physicians decreased by 25%.[19] It has been estimated that of the 24,378 medical students who were matched to residency positions in 2010, only 3,891 to 4,385 (or between 16 to 18%) plan careers in primary care.[20] While primary care doctors constituted 50% of all physicians in 1950, they comprise only about 35% of all doctors today. [21]

Primary care physicians are projected to play an enhanced role as care-givers to an aging population. It has been estimated that 87% of Americans aged 65–79 live with at least one chronic medical condition,[22] and it is primary care doctors who will be expected to manage older patients with multiple ongoing medical concerns. A disproportionate amount of care will be required by those older patients with the highest acuity levels—the 5% of the population who account for 50% of Medicare costs and who will require time-intensive care management by primary care docs[23]

As far back as 2004, the AAFP warned in a report that "primary care will cease to exist in 20 years" if changes are not made.[24] A crisis also is foreseen in general internal medicine. Fewer medical school graduates are choosing internal medicine, and the majority of those who do go on to sub-specialize or focus exclusively on inpatient (i.e. "hospitalist") medicine. In 2006, the American College of Physicians, which represents internal medicine practitioners and is the second largest physician organization in the United States, issued an Alert stating, "primary care, the backbone of the nation's healthcare system, is at grave risk of collapse."[25]

A key reason for the decline in interest in primary care is the pronounced disparity in incomes between primary care doctors and specialists. It is not uncommon for specialists to earn two or three times the annual income typically earned by primary care doctors.

This disparity is created by a Medicare-driven reimbursement system that places a relative value on the services physicians provide. The procedures surgeons and other medical specialists typically perform are usually assigned more "relative value units" (RVUs) than the consultation and evaluation services primary care physicians typically provide. As a result, a primary care doctor may be reimbursed $100 for a half hour patient consultation while a surgical specialist may be reimbursed $450 for a 15 minute colonoscopy.[26] The Robert Graham Center for Policy Studies in Family Medicine and primary care projects that over a career, primary care physicians lose over $3 million in income due to their decision not to specialize.

Income disparities between primary care doctors and specialists are made more significant to medical graduates by the high cost of medical education. The average educational debt of U.S. medical school graduates today is $155,000,[27] compared to a median debt in 1984 for public medical school graduates of $22,000 and a median of $27,000 for private medical school graduates.[28] It has been calculated that the monthly payment on a debt of $150,000 at an interest rate of 2.8% is $1,761, a particularly burdensome amount for primary care doctors to sustain.

These income disparities have helped to create a caste system in medicine with specialists at the top and primary care doctors on the bottom.

In its survey of primary care physicians, Merritt Hawkins asked primary care doctors about their relative standing in the medical profession:

RELATIVE TO SURGICAL AND DIAGNOSTIC SPECIALISTS, WHICH BEST DESCRIBES WHERE PRIMARY CARE PHYSICIANS STAND IN THE MEDICAL HIERARCHY?

Top Dogs	Equal Partners	Junior Partners	Second Class Citizens	N/A
3%	14.7%	31.4%	53.69%	1%

Source: Merritt Hawkins 2007 Survey of Primary Care Physicians/Physicians Practice Magazine

The income gap is only one reason why many primary care doctors believe they are second class citizens in the medical hierarchy. Primary care doctors also experience a less controllable lifestyle than do specialists such as radiologists, anesthesiologists, emergency physicians and others who work regular shifts. Given their long, erratic hours, their struggle for comparatively less reimbursement, the many duties for which they are not compensated, and the onerous amount of paperwork they are required to complete, many primary care doctors are reaching the breaking point.

In 2008, Merritt Hawkins conducted a survey on behalf of The Physicians Foundation that elicited responses from some 12,000 physicians, about 9,000 of them in primary care. Thousands of physicians who responded to the survey included written remarks regarding their views on medical practice. The following comment from a family practitioner is representative of many of the comments received:

"Something has got to be done and urgently to assist physicians, especially primary care physicians, to incentivize medical students to go into primary care and help those of us who are burned out to find renewed joy in seeing patients. Malpractice, government regulations, EMRs–all have their hands out wanting and expecting more time, money and effort just to maintain what we have. The whole thing has just spun out of control. I plan to retire early even though I still love seeing patients. The hassles are just too great."

Source: The Physicians Foundation. The Physicians' Perspective: Medical Practice in 2008.

Fewer than one-third of primary care physicians surveyed indicated that they would choose primary care if they had their careers to do over:

IF YOU HAD YOUR CAREER TO DO OVER, WOULD YOU:

Choose a surgical/diagnostic specialty	41.03%
Choose primary care	27.67%
Choose not to be a physician	26.69%
Choose a non-clinical path within medicine	4.69%

Source: The Physicians Foundation. The Physicians' Perspective: Medical Practice in 2008.

Health reform addresses primary care/specialist income disparities through a provision that allows for incentive payments equal to 10% of a primary care practitioner's allowed charges under Medicare Part B for primary care services provided on or after January 1, 2011 and before January 1, 2016. A primary care practitioner is defined as a family physician, general internist, geriatrician or pediatrician. Nurse practitioners, physician assistants and clinical nurse specialists also are included in the definition. Primary care services eligible for the 10% increase include specific Healthcare Common Procedure Coding System (HCPCS) codes that cover office visits, nursing home visits and home healthcare visits.

The codes designated in the law are:

99201-99215

99304-99340

99341-99350

These codes can be modified, however, by the secretary of HHS. To qualify for the bonus, primary care services must account for at least 60% of a physician's allowed charges under Medicare Part B. Qualifying physicians will be paid by CMS on a quarterly basis. CMS will identify doctors eligible for the increase on their 2009 claims data and provider identifier number. The payment is intended to be automatic and should not require physicians to additional substantive paperwork.

A difficulty in the requirements arises for those primary care physicians who have a wide scope of practice that includes the provision of surgery and tests often performed by specialists. For that reason, rural physicians in particular, who frequently provide a wide scope of services, may find it difficult to meet the 60% threshold required by the law.

More broadly, the increase is unlikely to persuade medical students facing an average of $155,000 in debt that primary care offers a reasonable economic alternative to surgical and diagnostic specialties. The American Academy of Family Practice indicates that on average, 25% of a family physician's revenue is derived from Medicare. A family physician in a thriving, mature practice earning $200,000 a year would hypothetically be eligible for a 10% bonus on some $50,000 in Medicare payments (though it is unlikely that all $50,000 would fall under the eligible codes). This would result in a bonus of $5,000—or a 2.5% increase in the physician's overall income. Because general internists often see a higher percent of Medicare patients than family physicians, their bonuses would be greater, as would bonuses for geriatricians. Pediatricians would see minimal to no Medicare bonus gains. All general surgeons who perform major procedures in HPSAs will be eligible for a 10% bonus payment from 2011 through 2015.

The chart below compares average incomes for primary care doctors earning a projected bonus through health reform to incomes for surgical and diagnostic specialists. Average incomes are derived from Merritt Hawkins' annual review of physician recruiting incentives showing salaries offered by medical groups and hospitals recruiting physicians. These number are exclusive of signing bonuses or production bonuses.

AVERAGE INCOME, PRIMARY CARE (W/MEDICARE INCREASE) VS. SPECIALISTS

Family Practice: $175,000 + 2.5% Increase	$179,375
Internal Medicine: $191,000 + 5%-10% Increase	$200,550-$210,100
Pediatrics: $180,000 + 0% Increase	$180,000
General Surgery (HPSAs only) $314,000 + 5%	$329,700
Anesthesiology	$331,000
Radiology	$417,000
Cardiology (Invasive)	$495,000
Cardiology (Non-Invasive)	$420,000
Dermatology	$316,000
Gastroenterology	$411,000
General surgery	$314,000
Oncology	$385,000
Orthopedic Surgery	$519,000
Urology	$400,000

Source: Merritt Hawkins 2010 Review of Physician Recruiting Incentives

It is evident that though the Medicare bonus may make a positive impact on income for primary care doctors, it will leave the economic scales still tipped very much in the favor of specialists.

Of more impact on medical student career choices may be the ongoing cuts to Medicare reimbursement to specialists that have taken place independent of health reform. Within the last year, Medicare has implemented a series of reimbursement cuts for services provided by cardiologists, radiologists, oncologists and other specialists. Fees for echocardiograms, for example, were shrunk by about one-third, while reimbursement for nuclear scans was cut by close to 40%.[29] The American College of Radiology (ACR) estimates that $3 billion in Medicare reimbursement for radiology services will be cut in the next ten years as a result of a reimbursement formula that assumes medical imaging equipment worth more than $1 million will be used 75% of the time (rather than 62.5% under the current formula) in outpatient centers starting in 2011. This standard will be particularly hard to meet in rural areas where imaging machines may be used less frequently than in urban or suburban areas.

Fees for patient consultations that specialists provide at the request of referring practitioners also have been reduced. These fee cuts are separate from the 23% cuts in Medicare reimbursement to doctors necessitated by Medicare's Sustainable Growth Rate formula (SGR)—cuts which have been repeatedly put off by Congress and which were not addressed by health reform.

A slight increase to primary care reimbursement combined with steep cuts in reimbursement for specialists may cause more medical graduates to select primary care, mostly by reducing the appeal of surgical, diagnostic and other specialties—though continuing material financial imbalances make this unlikely. Nevertheless, some medical graduates may forgo the extra training that becoming a specialist entails if they can earn roughly the same amount practicing family medicine, general internal medicine or pediatrics.

A system which robs Peter to pay Paul is flawed, however, and will only ameliorate one problem at the expense of exacerbating another. While the physician shortage is felt to be most pronounced in primary care, shortages of specialists also are emerging. The American College of Surgery (ACS) has been particularly vocal in warning of a shortage of general surgeons. In 1980, 945 newly trained general surgeons were certified in the United States.[30] In 2008, the number was essentially the same —972—despite a population increase of over 75 million people. [31] Speaking to the Washington Post, George Sheldon, director of the ACS' Health Policy Institute said, "The shortage of general surgeons is at crisis dimensions." If the trend continues, he noted, "quality of healthcare will suffer."[32]

The shortage of psychiatrists also is projected to be particularly acute. While over 30% of all practicing physicians in the U.S. are 55 years old or older, in psychiatry the number is 52%.[33] The number of psychiatrists being trained is wholly insufficient to replace those who will soon retire. It is projected that more than four times the current number of geriatricians will be needed by 2020 to serve the nation's aging population.[34] A study by the Lewin Group projects the U.S. will need an additional 1,050 gastroenterologists by 2020, if current rates of colorectal cancer screenings continue.[35] Should colorectal cancer screening rates increase by 10%, 1,550 gastroenterologists will be needed.[36] The American Society for Clinical Oncology has projected a shortage of 4,080 oncologists by 2020[37]. Other medical specialty societies and policy centers have warned of shortages in specialties such as allergy and immunology, cardiology, dermatology, emergency medicine, endocrinology, neurosurgery, pediatric subspecialties and rheumatology. While the AAMC has projected a 37% deficit of primary care doctors by 2025, it also has projected a 33% deficit of surgical specialists, a 23% deficit of "other patient care physicians," and a 7% deficit of medical specialists.[38] In an October, 2010 physician workforce update, the AAMC projected a shortage of 33,100 non-primary care doctors by 2015, including shortages of cargdiologists, oncologists and emergency medicine physicians.

A greater number of specialists will be required to care for a population experiencing its fastest growth among the elderly. It should be considered that demographics in the United States are undergoing a major transformation and that in 15 years the entire population will be as old on average as the population of Florida is now. Though primary care physicians will be needed to coordinate care for the elderly, it is specialists who provide key treatments, procedures and monitoring of elderly patients as organ systems begin to fail, and more will be required as some 75 million baby boomers begin to access Medicare in 2011. Health reform's provisions to grow physician supply are almost entirely centered on increasing the number of primary care doctors (and, to some extent, general surgeons) and do not make provision for the emerging shortage of specialists. Pursuant to the goals of reform, Congress should consider removing the cap on Medicare funded GME in order to train more primary care physicians and more physicians in specialties where shortages are deemed most acute.

Effect on Physician Distribution

There has been a long-standing maldistribution of physicians in the United States, with physician shortages being particularly severe in rural and inner city areas. HHS currently designates over 6,200 primary care Health Professional Shortage Areas (HPSAs) nationwide in which 65 million Americans live.[39] Sixty-seven percent of primary care HPSAs are in non-metro areas. Primary care HPSA designations are assigned to areas in which the ratio of primary care providers to population is less than 1: 2,000. HHS projects it would take 17,000 additional primary care providers to achieve a 1:2000 ratio in all primary care HPSAs.[40] HHS also designates 3,291 mental health HPSAs nationwide in which 80 million Americans live. Mental health HPSA designations are assigned to areas in which the ratio of behavioral health providers falls below 1: 10,000 HHS projects it would take 5,338 providers to achieve this ratio in the 3,291 mental health HPSAs.[41]

Health reform seeks to address the maldistribution of physicians by increasing funding for the National Health Services Corps (NHSC), by promoting physician training in outpatient settings, and by providing additional funding for community health centers, which provide care in medically underserved areas.

These measures are appropriate and broad enough to eventually improve access to medical services for some patients in medically underserved areas, but they will be insufficient to substantively rectify physician maldistribution, and no long-term solution to this problem appears imminent.

Despite the additional funding, it is likely that the NHSC will have difficulty in achieving its goal of attracting 15,000 clinicians (including primary care physicians and physician assistants) to underserved areas. One reason for this is that an increasing number of hospitals, medical groups and other organizations, many of them in areas not designated as HPSAs, are offering educational loan forgiveness as part of their physician recruiting incentive packages.

In its 2010 *Review of Physician Recruiting Incentives,* Merritt Hawkins examined the salaries and other incentives offered to physicians in over 2,800 physician search assignments conducted from April 1, 2009 to March 31, 2010. Educational loan forgiveness was offered in 38% of search assignments Merritt Hawkins conducted during that time, up from 14% in 2005.[42] A growing number of health facilities are using educational loan forgiveness as a difference maker when recruiting hard to come by primary care physicians and specialists, so that physicians do not have to turn to the NHSC in order to obtain debt relief.

In addition, the majority of Corps members do not stay in their initial assignment locations once their obligation period is over. One study indicated that only 20% of NHSC members stayed in the county of their original assignment, though an additional 20% continued to practice in a rural area.[43] While the study concluded that Corps members "account for a considerable proportion of all physicians in the most rural U.S. counties" the problem of physician retention still is one facing a great many rural hospitals, medical groups and other facilities. The challenges health facilities face in retaining NHSC physicians were recently detailed in an article in The Washington Post, which noted the inability of many rural areas to supply the technology, cultural and social amenities many young physicians prefer.[44]

Health reform seeks to address the retention issue by expanding training opportunities in outpatient settings, allowing medical residents to develop a feel for practice away from large tertiary teaching

facilities based in major metropolitan areas. There is some question as to whether training in outpatient environments can provide the type of comprehensive medical experience residents need to become competent practitioners. Putting that question aside, however, it may be that physicians trained in rural or other underserved locations will elect to practice in such locations. If so, these physicians will be a welcome addition to the workforce in traditionally underserved areas.

The addition of several thousand physicians to underserved areas clearly would be beneficial, but health reform will not change the fundamental conditions of medical practice prevalent in underserved areas–rural areas in particular. These conditions include lack of medical specialty backup, reduced access to electronic medical records, comparatively little call coverage, lack of cultural and entertainment venues, and few professional opportunities for physician spouses. For these and other reasons, few medical residents express an interest in rural practice. In a survey of final-year medical residents conducted by Merritt Hawkins, only 4% of residents indicated they would prefer to practice in a community of 25,000 or less (see chart).

BASED ON POPULATION, IN WHAT SIZE COMMUNITY WOULD YOU MOST LIKE TO PRACTICE?

10,000 or Less	3%
10,001 to 25,000	1%
25,001 to 50,000	13%
50,001 to 100,000	19%
100,001 to 250,000	23%
250,001 to 500,000	20%
500,000 to 1 Million	15%
Over 1 Million	6%

Source: Merritt Hawkins. 2008 Survey of Final-Year Medical Residents

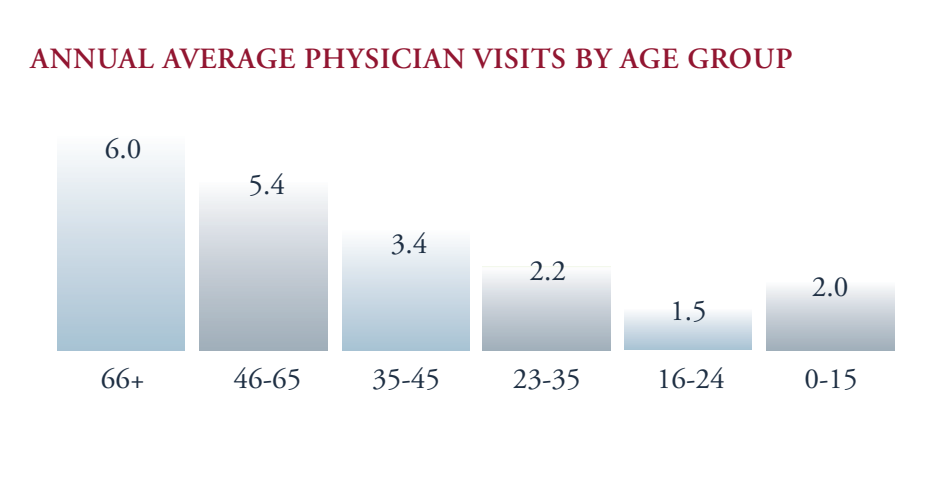
While health reform may ameliorate to some extent the maldistribution of physicians, the Advisory Panel anticipates that the shortage of doctors in rural and inner-city areas will remain a basic fact of life for the foreseeable future.

Effect on Physician Demand

Health reform includes provisions that will increase the number of physicians trained in the United States by several hundred a year–though these additional physicians are still years away from joining the work force. Additional provisions in the law may result in several thousand physicians practicing in underserved areas rather than in areas that traditionally have not been underserved–but which may face emerging physician shortages now or in the near future.

In addition to its limited effect on the supply of physicians, health reform will have a considerable impact on demand for physician services by extending medical coverage to over 30 million people. The effect this will have on demand for physician services will be substantial, though not immediate. The first expansion of medical coverage will occur by 2014, when 19 million currently uninsured people are expected to obtain coverage. The second expansion will take place by 2019, when the total number of newly insured will reach 32 million. Of the newly insured, approximately 16 million are expected to receive coverage through Medicaid.

Not all newly insured patients will have a pronounced need for medical services. An AAFP survey indicates that family physicians provide charity care to an average of nine patients per week,[45] while the AMA estimates that physicians provided $24 billion in charity care in 2008—numbers that suggest some uninsured patients do have access to primary care physicians. In addition, through community health centers, emergency departments and other safety net facilities the uninsured are able to obtain at least some level of access to medical services. Of the newly insured, several million will be young people who are relatively healthy and who generate few physician visits compared to other demographic groups (see chart below).



Source: Bureau of Health Professions

However, millions of new patients will be comprised of the chronically sick who have been uninsurable in the past as well as poor and minority population segments with high acuity levels and a reservoir of healthcare needs. These patients can be expected to significantly increase demand for doctors.

The Lewin Group has projected that universal access to medical coverage would create the need for 35,000 additional physicians,[46] while the AAMC projects universal access would increase the physician deficit by 31,000 physicians. In October, 2010 the AAMC released revised projections from its Center for Workforce Studies indicating that doctor shortages will worsen through 2025 in part due to health reform. While previous AAMC projections showed a baseline shortage of 39,600 doctors by 2015, revised, post-reform projections show a baseline shortage of 63,000 doctors by 2015.

Though health reform will not achieve universal access, it can be presumed that 32 million patients will generate more physician visits per capita after they have obtained medical coverage than they generated prior to obtaining coverage. Two additional visits to a primary care physician per capita by

the newly insured would result in 64 million additional visits annually. According to the Medical Group Management Association's 2010 Physician Compensation and Production Survey, primary care physicians (family physicians and general internists) handle an average of approximately 4,000 ambulatory patient encounters each year.[47] It therefore would require some 16,000 FTE primary care physicians to absorb additional patient encounters generated by the newly insured, assuming an increase of two physician visits per 32 million population.

Health reform does include provisions that may depress utilization of health services. By taxing expensive health plans it may reduce unnecessary tests and treatments. In order to compete for customers, insurance plans available through state exchanges may reduce costs by refusing to pay for certain services. Responding to cost pressures, employers may offer less expensive plans with higher deductibles and co-pays, discouraging employees from seeking non-urgent care.

It should be considered, however, that health reform also mandates that insurance plans pay for preventive services such as immunizations, preventive care for infants, children and adolescents, and additional preventive screenings for women, eliminating co-pays and deductibles. In 2011, co-payments for proven preventive services will be eliminated in Medicare and Medicaid, and incentives will be available to encourage Medicare and Medicaid beneficiaries to complete behavior modification programs. This will facilitate greater access to primary care physicians, who typically provide preventive services, and could easily lead to many more physician visits per capita than calculated above.

While it is difficult to project with certainty the level of additional demand for physician services that health reform will create, a harbinger is provided by Massachusetts, which in 2006 enacted a health reform plan similar to national health reform.

The Massachusetts plan succeeded in providing coverage to hundreds of thousands of previously uninsured patients, and 98% of Massachusetts residents now have health coverage, a higher percentage than any other state.[48] However, there have been various reports that patients in Massachusetts have had difficulty scheduling doctor appointments since the state reform plan took effect and that many doctors in the state are no longer seeing new patients.

According to the Massachusetts Medical Society, 40% of family physicians in Massachusetts no longer accept new patients, up from 30% in 2007.[49] Almost 60% of general internists have stopped taking new patients, up from 49% in 2007.[50] The average wait time to see a primary care physician in Massachusetts is 44 days.[51]

Responding to cost pressures, employers may offer less expensive plans with higher deductibles and co-pays, discouraging employees from seeking non-urgent care.

In its 2009 Survey of Patient Appointment Wait Times, Merritt Hawkins tracked how long it takes patients to schedule doctor appointments in 15 major metropolitan areas for five different medical specialties. Boston had the longest average wait time—50 days (see chart below).

AVERAGE PATIENT APPOINTMENT WAIT TIMES

Boston	50 days
Philadelphia	27 days
Los Angeles	24 days
Houston	23 days
Washington, D.C	23 days
San Diego	20 days
Minneapolis	20 days

Source: Merritt Hawkins 2009 Survey of Physician Appointment Wait Times

The average wait time to see a family physician in Boston as tracked in the Merritt Hawkins survey was 63 days, longer than for any other metropolitan area. This in spite of the fact that Massachusetts has 107.8 primary care doctors per 100,000 population, the third highest rate in the nation (nationally, the rate is 79.4 primary care physicians per 100,000 patients).[52] These wait times may signal what can be expected in some markets as more patients obtain coverage.

Prior to reform, as referenced above, a wide range of organizations projected a growing shortage of primary care and specialist physicians in the United States. Health reform will exacerbate these shortages by significantly increasing the demand for physician services while only minimally increasing physician supply.

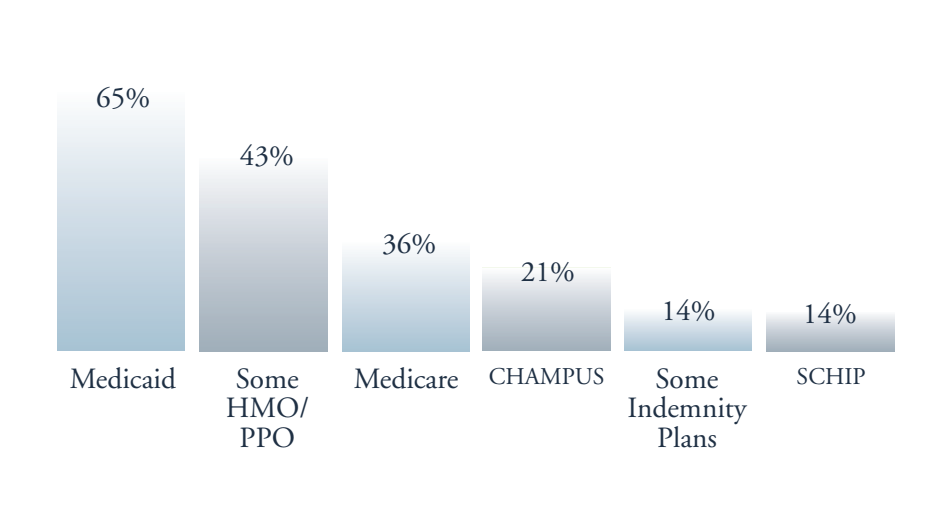
Effect on Medicaid/Medicare Patient Access

Health reform holds additional implications for physician supply, demand and patient access. Reform is projected to add 16 million people to the 47 million (19% of the U.S. population) who now receive benefits through Medicaid by expanding eligibility for the program to 133% of the federal poverty level.

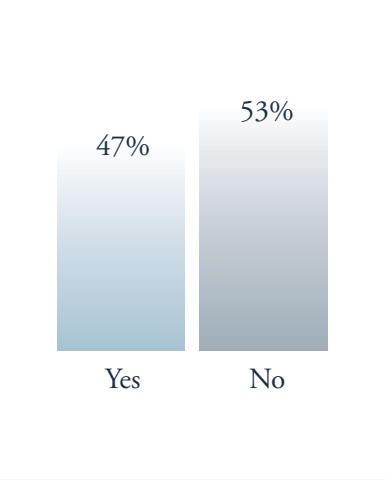
There is some question, however, as to whether physicians will be willing or able to see new Medicaid patients or those covered by other low reimbursing health plans. Similar questions arise regarding the ability or willingness of physicians post-reform to see Medicare patients.

In its 2008 survey, The Physicians Foundation asked doctors about health plans that reimbursed them at rates lower than their costs, if they had closed their practices to any category of patient, and, if so, which types (see below):

Which, if any, of the following payers provide reimbursement that is less than your cost of providing care?



Have cost/reimbursement or time issues in your practice compelled you to close your practice to any category of patient?



If yes, which types?

Medicaid patients	34%
Some HMO/managed care patients	30%
Certain managed care companies	26%
Indigent patients	16%
Medicare patients	12%
New patients	5%
Other	4%
Self pay patients	4%

Source: The Physicians Foundation. The Physicians' Perspective: Medical Practice in 2008

According to a national survey by the AMA and 17 medical special societies, approximately one in five physicians has eliminated or cut back on seeing Medicare patients, who comprise 15% of the U.S. population.[53]

Surveys taken of physicians in various states also indicate that a significant number no longer accept certain categories of patient, while others do not accept new patients of any kind. Thirty-six percent of primary care doctors in California do not accept Medicare patients, and 42% do not accept new Medicaid/Medi-Cal patients. The Connecticut State Medical Society reports that 28% of general internists and 26% of family physicians in the state are not accepting new patients, though Connecticut has the fourth highest ratio of physicians per population out of 50 states.[55] The proportion of Texas physicians accepting all new Medicaid patients has tumbled in the last decade, falling from 67% to 42%, according to a Texas Medical Association survey, while the number of Texas physicians accepting all new Medicare patients dropped from 78% to 64%.[56]

Merritt Hawkins' 2009 Survey of Patient Appointment Wait Times tracked the percent of physicians in 15 top metropolitan areas who are accepting Medicaid patients (see chart below).

AVERAGE MEDICAID ACCEPTANCE RATE FOR FIVE SPECIALTIES(%)

(Family Practice, Cardiology, Dermatology, OB/GYN, Orthopedic Surgery)

Minneapolis	82.4
Portland	81.4
Boston	68.2
San Diego	61.8
Seattle	58.2
Denver	57.4
Atlanta	55.0
Detroit	53.4
Houston	47.8
Miami	47.6
Washington, D.C	47.6
Philadelphia	46.0
New York	45.8
Los Angeles	40.2
Dallas	38.6

Source: Merritt Hawkins 2009 Survey of Patient Appointment Wait Times.

In the majority of markets examined in the survey, which was conducted prior to passage of health reform, over 40% of physicians indicated they do not accept Medicaid patients.

The Survey of Physicians and Health Reform conducted as part of this White Paper (see page 42) asked physicians if they believe health reform will compel them to close or to significantly restrict their practices to any category of patient. The majority (60%) said reform would compel them to close or restrict their practices to at least one category of patient. Of these, 93% plan to close or restrict their practices to Medicaid patients, while 87% plan to close or significantly restrict their practices to Medicare patients.

Health reform includes a temporary provision to encourage physicians to see Medicaid patients by increasing reimbursement for services provided to Medicaid patients to Medicare levels. Some physicians may be persuaded to see Medicaid patients as a result. For other physicians, Medicare

rates may not be sufficient inducement to see Medicaid patients. Note above that 36% physicians surveyed by The Physicians Foundation in 2008 reported Medicare pays less than their cost of providing care.

Dr. Richard Johnston of North Texas Medical Group, a member of the Advisory Panel for this paper and subject of a case study herein, indicates that a primary care practice reaches a financial tipping point when Medicare comprises 35% or more of payer mix. After this point, the practice is no longer viable. This is a particular challenge for older physicians, whose patient base often grows old with them and who may have practices mostly or entirely composed of Medicare patients.

For example, Dr. Johnston reports that his father, who also practiced internal medicine, ended his career with a largely Medicare practice which netted about 30% of the national average for internal medicine at that time. Dr. Johnston therefore was obliged to subsidize his father's practice in the three years prior to his father's retirement. The younger Dr. Johnston now is only able to see five Medicare patients a day and still maintain a financially viable practice. He is aware of some physicians who are compelled to drop patients when they turn 65 and become eligible for Medicare.

As financial and volume pressures on physicians increase, many Medicaid patients will be unable to access private practice physicians and will be compelled to rely on safety net providers. In addition, a growing number of Medicare patients also will have difficulty accessing physicians and will find their options limited.

Effect on Emergency Department Utilization

The result of limited physician availability is demonstrated in hospital emergency rooms. The number of people visiting hospital emergency rooms has increased in recent years, from 90.3 million in 1996 to 119 million in 2006.[57] Patient time spent in the ED also has increased. In 2009, the average wait time in the ED was 4 hours and 7 minutes, up by 4 minutes over 2008 but up by 31 minutes since 2002.[58]

It has been commonly thought that the uninsured were using hospital emergency rooms as a substitute for care and that the uninsured were largely responsible for crowding in the ER. Recently, this perspective has been challenged. In its report *"Emergency Department Visitors and Visits: Who Visited the ER in 2007"* the Centers for Disease Control and Prevention (CDC) found that:

> ER visits by uninsured patients are no more likely to be triaged as non-urgent than visits by insured patients. Contrary to popular perception, the CDC data show that uninsured patients are not coming to the ER for minor problems such as colds or headaches any more often than insured patients.
>
> People without a usual source of medical care were equally likely to have had one or more ER visits in one year than those with a usual source of medical care.

The CDC study suggests that one of the main reasons both insured and uninsured patients use the ER is convenience. Unable or unwilling to wait to until an office-based physician has an opening, both the uninsured and the insured visit the ER instead.

The expanded coverage provided through health reform was partly intended to alleviate ER utilization, which is comparatively expensive, by giving more patients access to a regular physician. However, even prior to health reform many patients—including insured patients—were using the ER due to lack of timely access to a regular physician. A study by Dr. Peter Smulowitz at Beth Israel Deaconess Medical Center indicates that ER visits at six Boston–area hospitals grew between 2006 and 2008 despite the steep drop in the number of uninsured residents that resulted from Massachusetts' adoption of health reform.[59] The Boston Globe reported that the number of ER visits in Massachusetts grew by 7% between 2005 and 2007 while the cost of treating ER patients grew from $826 million to $973 million.

Since health reform will not significantly increase physician supply, it can be anticipated it will have little effect on hospital emergency department utilization. Many hospitals emergency rooms will continue to experience overcrowding and see a large number of patients seeking convenient care rather than emergency care.

The Boston Globe reported that the number of ER visits in Massachusetts grew by 7% between 2005 and 2007 while the cost of treating ER patients grew from $826 million to $973 million.

Effect on the Medical Practice Environment

The reluctance or inability of some physicians to see Medicaid and/or Medicare patients underscores the fact that patient access to physicians is in part a function of the medical practice environment. Given current reimbursement structures, government regulations, patient volumes, practice costs, malpractice issues and emerging differences in practice styles between older and younger doctors, physicians are adjusting their practices in ways that tend to reduce patient access. The Physicians Foundation survey conducted as part of this White Paper suggests this trend may be accelerated by health reform (see below).

CONSIDER YOUR PRACTICE PLANS OVER THE NEXT THREE YEARS AS REFORM IS PHASING IN. DO YOU PLAN TO:

Continue practicing as I am	26%
Retire	16%
Cut back on hours	19%
Relocate to another practice	14%
Cut back on patients seen	13%
Switch to a cash or concierge practice	16%
Switch to a non-clinical job within healthcare	12%
Work locum tenens	14%
Work part-time (20 hours per week or less)	8%
Seek a job/business unrelated to healthcare	12%
Close my practice to new patients	6%
Seek employment with a hospital	11%
Other	2%

Source: The Physicians Foundation. 2010 Survey of Physicians and Health Reform

Sixteen percent of physicians surveyed indicated they plan to retire sometime in the next three years. Given current physician demographics, it can be anticipated that the number of doctors retiring annually will significantly increase in the next five to ten years. Over one-third of active physicians in the United States are 55 years old or older, and many older doctors are reporting diminished professional satisfaction. Seventy percent of physicians 51 or older surveyed by The Physicians Foundation in 2008 said they find the practice of medicine either less satisfying or unsatisfying,

and over 45% indicated they would retire if they had the financial means to do so. Even prior to health reform, many physicians fifty or younger surveyed by The Physicians Foundation—with seemingly years of an active medical career in front of them—have expressed the desire to retire. Health reform, which represents an additional unwelcome change for many doctors, may prompt physicians to retire earlier than they otherwise would have, further eroding physician supply.

An additional 24% of physicians surveyed indicated that in the next three years they will take steps that would remove them from patient care roles, either by seeking a non-clinical job in healthcare, or seeking a job or business unrelated to healthcare. Many of these physicians also are dissatisfied with the current medical practice environment but may not have the means or inclination to retire. Instead, they are seeking administrative roles in hospitals or group practices, quality assurance roles in pharmaceutical companies, and other non-clinical positions. Others are seeking to parlay non-clinical skills they may have into fields outside of healthcare. Physicians have been known to segue into a variety of careers, including real estate and financial management, and several consulting firms have been established in recent years that specialize in assisting physicians with career transition.

Others physicians surveyed do not plan to opt out of clinical roles in the next three years, but 76% said they do plan to take one or more steps that would allow them to cut back in some way, by reducing their hours, reducing the number of patients they see, switching to a concierge practice, working locum tenens, working part-time, or closing their practices to new patients. Each of the these steps or a combination of them would be likely to reduce patient access to physician services.

Over one in four physicians (27%) said they would either cut back on their hours or work part-time during the next three years. That physicians are working fewer hours than they have in the past is a trend that predates health reform. A study published in the Journal of the American Medical Association (JAMA) shows that the average number of hours physicians work has declined significantly over the last several decades. According to the study, physicians worked an average of 55 hours a week from 1977–1997.[60] From 1996-2008, by contrast, physicians worked an average of 51 hours per week, a 7% decline.[61] The study's authors project that the reduction in physician hours was equivalent to subtracting 36,000 physicians from the work force. Notably, younger physicians (45 years old or younger) worked fewer average hours from 1996-2008 per week than the overall average (50 hours vs. 51).

Though younger physicians appear to work fewer hours than older doctors, the JAMA study showed a stronger link between decline in physician work hours and decline in physician reimbursement than any link between physician work hours and age. The study suggests that as doctors of all ages are paid less for their efforts they see less reason to put in extended hours. A recent article in Health-Leaders regarding the study noted that, "Adjusted physician fees dropped by 25% between 1996 and 2006, and the hours worked by physicians strongly correlated with the fee indexes from the prior year. Researchers determined that physician hours worked were lower than 49 per week in the metro areas with the lowest fees."[62]

Continued reductions in physician reimbursement, either resulting from health reform or independent of it, may further reduce the motivation physicians have to work extended hours, leading to an additional decline of physician FTEs.

Sixteen percent of physicians said they would move to a cash only or concierge practice in the next one to three years, directly contracting with patients to avoid or reduce their interaction with third party payers. This trend also pre-dates health reform. Approximately 5,000 physicians are in concierge practice today,[63] a significant increase from four or five years ago when this style of practice was a rarity. In this practice model, physicians will offer expanded access to services to a limited number of patients, typically from 400 to 600, obliging the majority of patients (often 1,000 or more) to find another doctor. Should more physicians move the concierge model, overall physician availability will decrease.

Eleven percent of physicians said they would become hospital employees in the next one to three years, another trend pre-dating health reform. The Medical Group Management Association (MGMA) reports that two-thirds of physicians were independent practitioners in 2005. By 2008, the majority (52%) were employees.[64] Similarly, 52% of Merritt Hawkins' physician search assignments in 2009 featured hospital employment of physicians, compared to 19% in 2005. Tired of the risks and rigors of independent practice, a growing number of doctors are seeking the security and relative simplicity of hospital employment. Forty-one percent of physicians who responded to the Survey of Physicians and Health Reform already are employees. As physicians transition from business owners/entrepreneurs to employees, they are less likely to put in the long hours associated with traditional private practice, further diminishing FTEs. Only 26% of physicians said they plan to continue practicing as they are in the next one to three years.

Not all physicians, or even the majority, follow-through on the intentions they express in surveys. Moreover, historically, physician dissatisfaction has not been a major contributing factor to physician attrition. It is therefore unlikely that 40% of doctors will opt out of patient care in the next one to three years by retiring, seeking a non-clinical job in healthcare, or seeking a job or business outside of healthcare, as the survey suggests. It also is unlikely that the majority will move to part-time work, move to a concierge practice, or other otherwise limit patient access to their services. A physician exodus or practice restructuring on any such scale would clearly be disastrous and is not foreseen.

However, even if ten percent of physicians take steps limiting patient access to their practices in the next three years by opting out of patient care or by cutting back in some way, tens of millions of patient visits will have to be absorbed by other physicians or by other types of providers. This contingency, spurred in part by health reform, is possible and even probable, as physician dissatisfaction reaches new levels and as more physicians "refuse the bit."

That is not to say that health reform holds no positive implications for the medical practice environment and the readiness of physicians to practice in that environment. Health reform includes provisions that may alter the medical practice environment in such a way as to reenergize some physicians, militating against early physician retirement and the desire of many physicians to work less or reduce the number of patients they see. Among these provision is the access to medical coverage reform will create for millions of Americans. As reform is implemented, physicians will see fewer charity patients and some will feel less angst about the nation's high number of uninsured patients, even though access problems are likely to continue.

In addition, reform promotes new methods of delivery such as the medical home that some physicians will find both emotionally and financially rewarding. The promotion of greater physician/

hospital alignment also may prove attractive to some physicians, as will greater utilization of evidence-based medicine and the use of electronic health records.

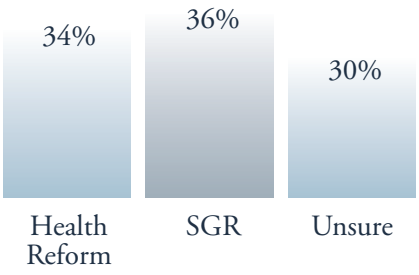
Also of note, reform calls for national rules to be developed starting in 2010 and implemented between 2013 to 2016 to standardize and streamline insurance claims processing requirements. These changes are intended to make it easier for physicians to track claims, improve revenue cycles and lower overhead.

Research indicates that doctors spend almost three weeks a year on health plan related tasks. University of California at San Francisco researchers calculated that the annual cost of performing billing related tasks comes to about $85,276 per physician.[65] According to the MGMA, physicians work with an average of 12 different health plans, all of which require them to adhere to different procedures.[66] Any effort to standardize or automate claims processing will therefore be welcomed by physicians if they achieve real process improvements.

However, reform also includes both omissions and provisions likely to exacerbate elements of the medical practice environment that lead physicians to premature retirement and the desire work less or otherwise reduce their exposure to clinical practice.

Just as reform did not address the key factor limiting physician supply—the cap on Medicare funding for physician GM—it did not address two key factors that are of great concern to physicians and which have important workforce implications. First, the new law did not include a "fix" to Medicare's Sustainable Growth Rate (SGR) formula which some physicians believe will have more impact on their practices than reform itself (see below).

WHICH IS LIKELY TO HAVE THE GREATEST IMPACT ON YOUR PRACTICE?



Source: The Physicians Foundation. 2010 Survey of Physicians And Health Reform

Doctors responding to The Physician Foundation's 2008 survey identified "reimbursement issues" as the primary cause of their professional dissatisfaction. Doctors have been particularly vocal about the escalating cuts to physician Medicare reimbursement mandated by SGR, which now stand at 23% effective December 1, 2010. Absent a fix of SGR, or given a resolution that leads to further significant cuts in reimbursement, the movement of physicians towards retirement and work cut-backs can be expected to accelerate. Reform left SGR unresolved and no solution likely to be embraced by the majority of physicians appears imminent.

Second, health reform provides no immediate relief to physicians in the area of malpractice, an issue of primary concern to many doctors. A report issued by the AMA finds an average of 95 medical liability claims filed for every 100 physicians, or virtually one per doctor.[67] About 61% of physicians 55 and over have been sued, with certain types of physicians more subject to lawsuits than others. For example, the number of claims filed against general surgeons and obstetrician/gynecologists is more than five times higher than for pediatricians and psychiatrists.[68] Before they reach 40, more than 50% of obstetrician/gynecologists have been sued, while 90% of general surgeons over 55 have been sued.[69]

Though physicians prevail in 90% of the cases that go to trial, malpractice insurance is expensive, as is the process of malpractice defense. The average defense costs per claim range from a low of approximately $22,000 for claims that are dropped or dismissed to a high of over $100,000 for cases that go to trial.[70] Physicians also object to the practice of defensive medicine in which they feel compelled to order tests or treatments merely as a hedge against potential lawsuits, adding over $100 billion to the nation's healthcare bill annually according to one estimate.[71]

Health reform, however, calls only for five-year demonstration grants to states to develop alternatives to current tort litigations, leaving in place a status quo that is generally unfavorable to physician work force retention.

To these omissions must be added an escalating level of legal compliance considerations mandated by health reform, a subject addressed in more detail elsewhere in this White Paper (see page 66). Health reform also will restrict the ability of physicians to buy-into and practice in physician-owned specialty hospitals, an alternative practice setting that many physicians find attractive. Further, reform requires the Department of Health and Human Services (HHS) to set standards for quality and safety measures that physicians will have to meet. The American Reinvestment and Recovery Act (ARRA) provides billions of dollars in funding for physicians who engage in the "meaningful use" of Health Information Technology, which is intended to streamline the reporting process. The meaningful use rules themselves, however, are viewed by many physicians as compounding the complexity of the medical practice environment, and many doctors are dubious about the ability of IT to add value to their practices. Deductions in Medicare payments loom for physicians who do not adopt Health IT by 2015. Many older physicians with whom Merritt Hawkins has spoken have indicated they plan to "hang on" until these penalties take effect and then retire or opt out of clinical medicine.

On balance, therefore, health reform is unlikely to significantly ameliorate those elements of the medical practice environment that many doctors find objectionable, including problematic reimbursement, malpractice risk, and a high level of regulation and paperwork. In many ways, it will compound these problems. As a consequence, many physicians will opt for early retirement or non-clinical roles, while others will take various steps likely to reduce access to their services. This will have the general effect of compounding physician shortages nationwide.

To ensure adequate patient access to medical services will require a reassessment of the medical practice environment as it exists today and as it will likely evolve under health reform. It will not be enough to train more physicians, though that is necessary. The medical profession itself must be made robust and rewarding enough to retain physicians currently in practice and to attract the best students to the field. This will require a long-term reevaluation of physician reimbursement, a reassessment of current malpractice law, and an adjustment of the regulatory environment in which doctors practice. These changes are necessary to ensure the continued viability of the medical profession and full participation and engagement of the medical work force. Only an engaged, motivated physician work force will be able to provide accessible, quality care to a population that is growing, aging and more widely insured.

Effect of Reform on Physician Practice Patterns

The shortage of physicians pre-dates health reform and has been driving changes in physician practice patterns and patient care delivery for several years. These changes will be accelerated by reform and will require many physicians to restructure their practices and incorporate new resources and methods into their operations. Physicians will have to find ways to provide treatment to a greater number of patients and to patients whose medical needs may be both more varied and more acute than in the past.

There are various ways of extending the physician work force that may become more prevalent as reform adds million of patients to the ranks of the insured and of restructuring practice patterns to respond to the post-reform environment. These include:

REDEFINING ROLES

In an era of physician shortages it will be necessary for physicians to practice to the limits of their training. As Richard Cooper, MD of the University of Pennsylvania has observed, specialists will focus their efforts on technologically advanced care of patients with complex medical conditions, using cutting edge diagnostic and surgical tools. Continuing medical advancements will require specialists to practice in ever narrower but deeper silos, driving the need for cooperation between specialists and the availability of primary care physicians to oversee and coordinate care, in some cases through the medical home. Like specialists, primary care physicians will devote more time to treating complex cases and will manage patients with multiple chronic illnesses. Increasingly, they will manage the care of patients with uncomplicated conditions through the supervision of a growing number of non-physician clinicians (NPCs), including nurse practitioners (NPs), physician assistants (PAs), and pharmacists, who in some markets are providing oversight for patients with chronic diseases such as diabetes.

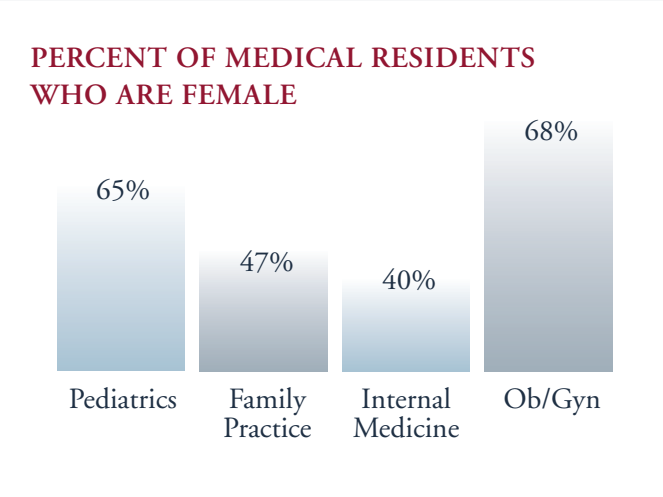
Health reform increases Medicare reimbursement by 10% for NPs and PAs practicing primary care. It also provides nurse midwives, a type of advanced practice nurse, with a Medicare raise to 100% of what obstetrician/gynecologists make, and allocates $50 million to nurse-managed clinics that offer primary care to low-income practices. In 2008, Massachusetts, a model for national reform, passed a state law requiring health plans to recognize and reimburse nurse practitioners as primary care providers. Insurers in the state now list NPs with doctors as primary care choices. These developments are part of a larger trend in which various types of clinicians are seeking more authority and autonomy, sometimes against the opposition of physicians.

In the interest of patient care, physicians should retain their supervisory role and the lines between physicians and NPCs should not be blurred. However, it is clear that as reform is implemented, many patients will be less likely to see a physician and more likely to see a NPC. This already is the case in many hospitals where NPs are doing tasks that residents can no longer perform due to limits on their work hours, as well as in rural and other underserved areas. NPCs also will play a significant role in the medical home and in aligned systems, as discussed earlier in this paper.

It should be noted, however, that the expanded use of NCPs will not in itself resolve physician shortages, particularly in primary care. Like physicians, many PAs and NPs are choosing to work in medical specialties. Only 37% of PAs and 67% of NPs practice in primary care areas. In Massachusetts, where NPs are listed as primary care providers, patients continue to have difficulty accessing services.

EMBRACING FLEXIBILITY

One practice style does not fit all today, and medical practices will need to be flexible in order to accommodate different practice preferences and changing physician demographics. Almost 25% of all practicing physicians are women today, as are 41% of all doctors under the age of 40. Female physicians are particularly concentrated in primary care (see below).



Source: American Medical Association: Physician Master File.

Female physicians often complete their training during their peak child bearing years, one reason why they work an average of 18% fewer hours than male physicians.[72] The growing number of female physicians has led to a comparatively new phenomenon in medicine—the rise of the part-time physician. A recent survey of physicians in California indicates that 16% of doctors in active care in the state work 20 hours a week or less.[73] While it is female doctors who typically seek part-time positions, both younger male and female physicians often express interest in working limited hours. Though it may create perceived inequities within a group, accommodating physicians with part-time schedules will be necessary, as these doctors represent a growing percentage of overall FTEs. It also will be necessary to include locum tenens physicians, who often are older physicians and who represent a growing percentage of the physician workforce, into the staffing mix.

EXPANDING HOURS

Many physicians are under pressure from patients to expand their office hours, a trend that will be accelerated as health reform brings newly insured patients into the system. Expanded hours and greater provider accessibility are more characteristic of medical practices in other developed countries than in the United States (see graph below).

PHYSICIAN PRACTICES THAT CAN ARRANGE FOR PATIENTS TO SEE A DOCTOR OR NURSE AFTER HOURS

Source: 2006 Commonwealth Fund International Policy Survey of Primary Care Physicians

Expanding weekday and weekend hours often can be accomplished through the use of part-time physicians and NCPs. Some physicians, particularly those who remain in private practice, may be obliged to put in longer days in order to meet the needs of patients.

UTILIZING EMR/HEALTH IT

To date, EMR has a mixed record as a means of saving labor and extending the physician workforce. Installing EMR requires a considerable amount of physician time and often results in lost productivity. Once implemented, some physicians find EMR reduces their efficiency during patient appointments as they are required to do data entry. Dr. Richard Johnston, a Panelist for this White Paper, reports that while EMR in his practice offers quality of care benefits and some efficiency gains, his practice is still awash in paper received from hospitals, referring physicians, patients and others. Unless physicians are part of a truly integrated system, he believes, the "paperless practice" will remain an aspiration, not a reality. For physicians in an integrated model, however, EMR can have the net effect of extending the physician workforce through productivity gains.

Physician resistance to EMR persists, however, for a variety of reasons. Dr. Johnston indicates that he took charts home for a year and did data entry on his own in order to implement EMR in his practice. Nevertheless, to embrace the medical home model and to ramp up for evidence-based medicine, his practice must continuously add a plethora of patient tracking systems that he finds overwhelming and which he believes most physicians will not be able to implement without capital assistance. Data generated by The Physicians Foundation indicates

it costs $35,000 per-physician to implement EMR, and $15,000 per-physician to maintain, not factoring in lost productivity while systems are being installed. Physician Quality Reporting Initiative (PQRI) bonuses are not likely to offset these costs. Voice recognition software obviates the need for physicians to become data entry clerks, as did Dr. Johnston, and Advisory Panel member Claire Pomeroy, MD of UC Davis indicates all UC Davis staff physicians use it, though such software adds an extra layer of expense.

Smaller practice settings, such as community health centers (CHCs), are still playing catch-up when it comes to implementing EMR. Advisory Panel member Ron Yee, MD indicates that only 20% of CHCs have EMR because up to this point they have not had the capital necessary for implementation. Advisory Panel members also question the ability of EMR to withstand disasters or attacks. One such episode could cause irretrievable damage to a practice or a larger system.

Moreover, while EMR is a necessary part of consolidation and integration, Dr. Johnston notes it can be an obstacle to the integration process. Dr. Johnston found that the effort to consolidate his practice with others was hindered by the fact that each practice was wedded to its own system. Any practice that joined Dr. Johnston's had to abandon its own system, which many physicians were reluctant or unwilling to do.

Physicians often are split along generational lines regarding the use of EMR, with some older physicians resisting its use or avoiding locating to new practices that will require them to learn systems with which they are unfamiliar or toward which they are unfavorably disposed. By contrast, academic health centers are teaching new doctors with EMR and it is difficult to recruit younger doctors to practices that do not have it. Physicians also can be divided about EMR on specialty lines. The American Academy of Family Practice (AAFP) indicates that about 50% of its members have adopted EMR and that most realize EMR is critical for primary care, whereas surgical and diagnostic specialists may be less sanguine about its use.

Ultimately, Dr. Johnston indicates that EMR does improve efficiency, and that safety and quality issues demand its use—there is no method for obtaining comparative data without it. Panel members agree that EMR/IT is most powerful when it is transparent to the other physicians in the practice or system who can see what clinical standards are being used and where they rank in terms of productivity. Panel member David Spahlinger, MD states that practice guidelines are largely accepted by physicians as long as the data is driven by doctors themselves, and not insurance companies, and as long as guidelines change as evidence dictates.

Dr. Spahlinger notes that physicians are evolving from the practice of "intuitive medicine" to the practice of "precision medicine," and that EMR will eventually be universally embraced for this reason.

EMBRACING TELEMEDICINE

On August 18, 2010 California Governor Arnold Schwarzenegger announced the launch of the nation's largest "telehealth" network, which is ultimately intended to connect patients to hundreds of hospitals, clinics and physicians throughout the state. The network employs a broadband link separate from the Internet broadband that will be dedicated solely to healthcare information. The mission of the program is to increase access to physicians and other clinicians in underserved rural and urban areas. Among the first to connect to the network will be five University of California medical centers as well a variety of local clinics.

Sixty percent of the network's projected 850 providers will be rural with a primary care focus, though the network also will assist urban patients to see specialists.

In April, 2010, Park Nicollet Health Services in Minnesota rolled out an online diagnosis service offering diagnosis of minor problems such as bladder infections and allergies using technology developed by Minneapolis start-up Zipnosis. The service is part of a 12-month pilot project in which consumers can log on to **www.zipnosis.com** and spend five minutes answering questions about their systems. Nurse practitioners provide diagnosis, suggest treatment, and prescribe drugs at $25 per visit.

These initiatives are representative of a growing movement to extend the physician workforce through online technology. The practice has been a staple in radiology for a number of years, and can be as simple as two physicians discussing a patient over the phone or as complex as using satellite technology and videoconferencing to conduct a real-time consultation between physicians in two different countries.

Both physician and patient time can be saved through the use of virtual patient visits, a modern day version of the house call using online videoconferencing. Virtual doctor visits are not without controversy, however. Some physicians believe they are not a substitute for a traditional face-to-face exam. In Texas, the law requires doctors to establish a relationship with patients through means such as physical exam before they consult with patients or prescribe medicine online or over the phone.

Telemedicine also brings patients themselves into the clinical workforce by enabling them to help monitor their own care, ushering in the age of do-it-yourself medicine. Technology is available that connects patients with caregivers through wireless devices that allow patients to take readings on their weight, blood pressure and other key metrics. Remote monitoring technology can eliminate those doctor visits which merely reveal that "everything is still the same," thereby extending physician FTEs. Remote monitoring also can catch problems early, preventing hospitalizations or hospital readmissions and their attendant drain on physician time and resources.

Today, however, many physicians are not compensated for providing care not given during the course of face-to-face appointments. Reform does not include provisions that would compensate primary care doctors in particular for the numerous phone calls or emails they are obliged to make or return on behalf of patients. Such payments would considerably enhance the practice environment for primary care and other physicians, though most physicians continue to provide these services gratis.

Nevertheless, continuing isolation of rural and other underserved populations, physician shortages, improving technology, the expanding use of EMR, and the comfort level with computer technology of the young militate toward the growing use and acceptance of online medicine.

CREATING OPEN ACCESS

Traditionally, medical practices handle patient scheduling by maintaining a large backlog of future appointments. Wait times for appointments often can stretch into weeks or months. Once in the office, patients typically wait 20 minutes or more to see a doctor.[74] A typical day will include one or more patient cancellations and calls from patients with emergencies (real or perceived) asking to be squeezed in. Many doctors consequently run behind and have less time to spend per patient, leading to frustration for both parties.

In response, some physicians are discarding the traditional appointment book and opting for open access scheduling, also referred to as "same day" or "advanced-access" scheduling. In this model, which is promoted by the Institute for Health Care Improvement, a Cambridge, Massachusetts nonprofit organization formerly headed by Dr. Donald Berwick, the current head of the federal Center for Medicare and Medicaid Services (CMS, physicians leave most of their schedules open. Patients call in the morning and usually are assigned 15 minute time-slots on a first-call, first-served basis. Physicians may reserve two or three hours of the day for traditional scheduled appointments with a few extra slots for walk-ins or emergencies. Ideally, the number of cancelled appointments is reduced, and walk-in or emergency patients are accommodated without appointment disruptions and delays. The essence of the concept is to "do today's work today."

Though open access scheduling will do little to extend the physician workforce or reduce shortages, it is one way for physicians to cope with rising patient loads. Surveys indicate physicians with open access have relatively high patient satisfaction scores because patients have more immediate access and appointments are scheduled for 15 minutes rather than the customary[10]. The AAFP has resources to assist physician implement open access scheduling, including a case study published in the AAFP journal Family Practice Management.[75]

SHARING PATIENT APPOINTMENTS

Shared medical appointments (SMAs), also known as group appointments, are being used to extend the physician workforce in various sites of service nationwide. SMAs are scheduled for physicals, well-child check-ups, prenatal care, chronic illness management and other types of primary care, as well as for specialty care. Typically lasting 90 minutes, six to 15 patients participate, signing statements agreeing to keep information about the others confidential. Doctors take vital signs in front of the group but may examine patients in private rooms when necessary. Physicians bill the same for patients seen in a group as individually.

SMAs both extend physician FTEs and show positive signs for improving quality of care. A review of multiple studies that appeared in the Journal of Family Practice found that group prenatal care may reduce the rate of preterm births.[76] A 2006 review of nearly 20 studies published by the Journal of the American Board of Family Medicine called group appointments a "promising approach" and concluded that "there is sufficient data to support the effectiveness of group visits in improving patients and physician satisfaction, quality of care, quality of life and in decreasing emergency department and specialist visits."[77]

PERSUADING PHYSICIANS TO UN-RETIRE/WORK LOCUM TENENS

As noted above, it is anticipated that many older physicians, unhappy with the direction medicine has taken, will seek to retire as soon as possible. Nevertheless, it is less time consuming to return a nonpracticing physician to clinical medicine than it is to educate and train a new one. Given the economic downturn, some retired physicians may be open to returning to medicine. The rising use of temporary (i.e., locum tenens) physicians provides one avenue for physicians to unretire or to delay retirement. Staff Care, a national locum tenens staffing firm, estimates that 38,000 physicians now take at least one locum tenens assignment during the course of a year, up from 26,000 in 2004 (Staff Care is affiliated with Merritt Hawkins. Both are companies of AMN Healthcare). Locum tenens may extend total physician FTEs by keeping some doctors in the workforce who may otherwise have retired.

Several formal physician reentry programs exist, such as the Drexel Medicine Physician Refresher/Re-Entry Course of Drexel University College of Medicine in Pennsylvania and The Center for Personalized Education for Physicians based in Denver.[78] These programs address clinical issues but also may review electronic medical records, documentation changes, and health policy changes.

It cannot be anticipated, however, that a large number of physicians will return to clinical practice until physicians perceive that significant changes have been made to the medical practice environment, including a revision of current reimbursement systems and malpractice reform.

RETHINKING MEDICAL EDUCATION

Dr. Richard Cooper has observed that first-year residents accounted for 30% of all residents in the 1970s. By 1990, however, this number had declined to 22%, where it remains today. This means, in effect, that the average length of residency has increased from 3.5 years to 4.5 years. Training times have increased across the board, in part because a higher percentage of residents are in specialty training programs, which typically are longer than primary care programs. Because the lead-time to train a physician is so long, thought is being given to restructuring the traditional path to becoming a doctor. Texas Tech University is creating a three year medical degree family medicine track, reducing the time it takes to complete medical school by one year. Students will compete for spots and, if accepted, their tuition will be cut in half through the absence of the fourth year and forgiveness of first year tuition. Wide-spread adoption of a three year primary care track could both increase interest in primary care and accelerate the growth of the physician work-force. Dr. Cooper estimates that shortening residencies by an average of six months would allow a 10% increase in the number of first-year residents.

PROMOTING PREVENTION

Health reform mandates payment for preventive services that, by catching illnesses early and promoting wellness, may reduce the need for both primary care and specialist physicians, at least in the short-term (some data suggest that by prolonging life prevention ultimately leads to greater utilization of services during highly invasive end-stage care). Making preventive services accessible will be a challenge as millions of patients become newly insured. Expanding sites of service include federally qualified community health centers (CHCs) which will receive $11 billion in funding through health reform to pursue their mission of providing primary care to traditionally underserved populations. CHCs currently see approximately 20 million patients annually, a figure that is expected to double to 40 million as reform is implemented. Significantly enhanced primary care/preventive services provided through CHCs, though requiring additional physician resources in the short-term, may lead to lower utilization of specialist/emergency services, with the long-term effect of extending the physician workforce. A growing number of retail clinics also may serve a similar function. Mobile clinics, of which there are approximately 2,000 in the U.S.,[79] bring blood pressure, blood sugar, cholesterol and other simple tests to underserved population, are another method of delivering preventive services and reducing the strain on physicians.

EXPANDING MEDICAL TOURISM

Given current access and cost barriers facing many U.S. patients, a growing number of Americans are obtaining treatments and procedures overseas. Health reform may increase access to coverage, but co-pays and deductibles are likely to remain high for many, encouraging the proliferation of medical tourism. A migration of some patients overseas would reduce demand for domestic services and ease the physician shortage.

EXPANDING OPTIONS FOR CANADIAN MEDICAL GRADUATES

Graduates of Canadian medical schools are not considered international medical graduates, because their education, training and examinations closely mirror those in the United States. Based on their Canadian education and training, Canadian graduates can obtain medical licenses in the great majority of U.S. states. To obtain a temporary (H-1B) work visa, however, Canadian graduates need to complete the U.S. medical qualifying exam (the USMLE). This is a significant barrier to entry, which, if removed, would greatly enhance the ability of U.S. hospitals and other facilities to recruit Canadian physicians.

ACCOMMODATING GEN Y AND MILLENNIALS

Just as there are generational differences among physicians, there are generational differences among patients. Commonly observed characteristics of younger patients include a tendency to self-diagnose through online research, a desire to make physician appointments online, relatively less inclination to wait for appointments, and relative indifference to whether they see a physician or non-physician clinician. These proclivities will induce a growing number of physicians to embrace online resources such as practice web sites that feature online scheduling as well as patient education and interaction opportunities presented by Facebook and YouTube. In addition, the next generation of patients is likely to have high-deductible plans as the cost of insurance increases. As Dr. Johnston observes, the decision to "send a patient downstairs for a CT becomes more complicated if the patient has a $10,000 deductible and the CT will cost her $3,000."

A migration of some patients overseas would reduce demand for domestic services and ease the physician shortage.

Conclusion

Even with the embrace of the concepts described above, the physician shortage will continue, due in part to the long turnaround times necessary to train more physicians and to the large number of additional physicians needed. As the AAMC states in its report *The Complexities of Physician Supply and Demand,* "Even a robust expansion of GME capacity (from 25,000 new entrants to 32,000) would only reduce the projected shortage by 2025 to 54,000 doctors." [80]

Health reform ushers in an era in which the physician workforce will be strained to its limits and in which physicians will be seeking alternatives to traditional private practice. More physicians must be trained, and new practice patterns and new models of delivery will be needed to extend available physician FTEs. Just as important, efforts must be made to enhance the medical practice environment, by addressing reimbursement processes and inequities, instituting tort reform, reducing the bureaucratic burden on doctors and allowing them to retain their clinical autonomy. There is a direct link between the way physicians view their profession and the quality and access to care that patients receive. A robust and engaged medical profession is a necessary component of an effective, sustainable healthcare system.

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