



## Medicare Payment Reform Acutely Hindered by Shortage of Primary Care Physicians

From 2010 to 2020, the number of individuals over the age of 65 is forecast to increase from 40.3 million (13 percent of the total population) to 56 million (16.8 percent).<sup>1</sup> The aged account for a disproportionate 34 percent of healthcare expenditure, with Medicare spending per beneficiary increasing with each age cohort (65-74: \$7,859; 75-84: \$12,805; >85: \$13,788). Medicaid spending also rises per cohort.<sup>2</sup> Higher spending is consistent with an increase in the number and severity of co-morbid chronic conditions and the high cost of end-of-life care. Hospital care represents the single largest category of spending at 35 to 40 percent of the total.

Spending among the elderly is highly concentrated. In Medicare Fee-For-Service (FFS), five percent of beneficiaries account for 39 percent of expenditures, and 25 percent of beneficiaries account for 82 percent of the total. Conversely, 75 percent of beneficiaries account for 18 percent of expenditures. The vast majority of high cost beneficiaries, 71 percent, have five or more chronic conditions.<sup>3</sup>

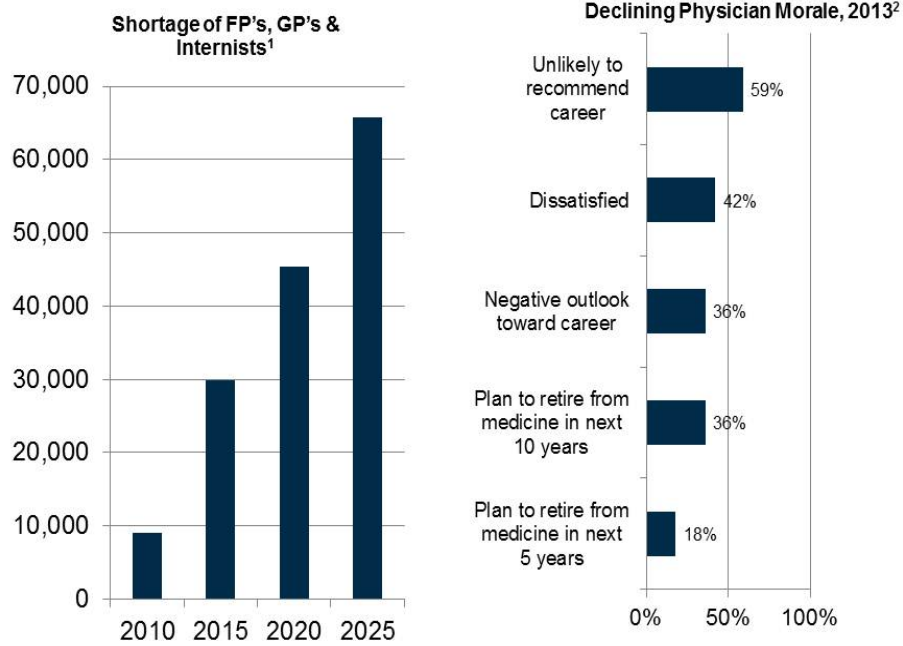
Importantly, both the Wagner Chronic Care Model (CCM) and Patient-Centered Medical Home (PCMH) approach recognize *the centrality of primary care physicians (PCPs)* to manage and coordinate the care of aging patients with multiple chronic conditions across the entire continuum. The Center for Medicare and Medicaid Services (CMS) also recognizes their importance as it institutes payment reform.

In this article, we discuss the worsening primary care physician shortages (by state), accelerating Medicare payment reform and the challenges associated with hospital investment in primary care. Without sufficient and compensated PCPs, value-based payment reform will not reach its potential.

### Shortage of primary care physicians worsening

A rapidly aging population, combined with Medicaid expansion, is expected to increase the demand for primary care physician services. Despite the increase in demand, the number of primary care physicians (family practitioners, general practitioners, internists) is forecast to remain relatively unchanged, leading to a worsening shortage. Primary care physicians are poorly compensated (family physicians: \$207,723; internists: \$231,533), earning 30 to 50 percent of many specialists, including those in orthopedics and interventional cardiology.<sup>4</sup> The advent of concierge medicine (smaller patient panels), combined with accelerated retirement from practice (due to declining morale) and fewer medical school graduates choosing primary care training, are worsening the shortage.

## SHORTAGE OF PRIMARY CARE PHYSICIANS PROJECTED TO WORSEN



Sources: <sup>1</sup>AAAMC. The Impact of health care reform on the future supply and demand for physicians: Updated projections through 2025. June 2010; <sup>2</sup>Filling the Void: Physician Outlook and Practice Trends, 2013. Reported by Jackson Healthcare. [http://www.jacksonhealthcare.com/media/191888/2013physiciantrends-void\\_ebk0513.pdf](http://www.jacksonhealthcare.com/media/191888/2013physiciantrends-void_ebk0513.pdf)

4

The shortage of primary care physicians varies by state. The U.S. average is forecast to decline by 27.9 percent from 2010 to 2020, from 6.9 to five primary care physicians per 1,000 individuals over the age of 65. Many of the states with the fewest available primary care physicians, already in the third and fourth (lowest) quartile, also have the highest rate of >65 years population growth: Arizona (72.4 percent), Nevada (63.7 percent), Florida (56.7 percent), New Mexico (54.2 percent), Texas (44.3 percent).

## SHORTAGE OF PRIMARY CARE PHYSICIANS VARIES BY STATE PRACTITIONERS/GENERAL PRACTITIONERS/INTERNAL MEDICINE

	Number	FP/GP/IM			Medicaid
		Per 1,000 pop >65			
1st Quartile	Physicians	2010	2020	% Change	Expansion
Alaska	749	13.6	7.6	-44.3%	
Massachusetts	7,862	8.7	6.6	-23.9%	Yes
New York	21,484	8.2	6.5	-21.2%	Yes
Maryland	6,314	8.9	6.4	-28.1%	Yes
Colorado	4,657	8.5	6.1	-28.4%	Yes
Illinois	12,061	7.5	5.9	-20.9%	Yes
Rhode Island	1,190	7.8	5.9	-25.0%	Yes
Minnesota	5,390	7.9	5.8	-26.6%	Yes
Connecticut	3,725	7.4	5.7	-22.9%	Yes
Vermont	791	8.7	5.7	-34.7%	Yes
Hawaii	1,529	7.8	5.7	-27.9%	Yes
New Jersey	8,912	7.5	5.6	-25.3%	Yes
Michigan	9,693	7.1	5.5	-22.2%	Yes
2nd Quartile					
Oregon	3,901	7.3	5.4	-26.0%	Yes
Washington	6,440	7.8	5.4	-30.7%	Yes
New Hampshire	1,437	8.1	5.4	-33.4%	Yes
California	33,878	8.0	5.3	-33.0%	Yes
Maine	1,601	7.6	5.3	-29.8%	No
Georgia	7,573	7.3	5.3	-28.4%	No
Utah	1,830	7.3	5.2	-28.5%	Debate
Ohio	10,564	6.5	5.2	-19.8%	Yes
Wisconsin	5,335	6.9	5.1	-25.9%	No
Virginia	7,243	7.4	5.0	-32.0%	Debate
Indiana	5,158	6.1	4.9	-19.3%	Debate
Pennsylvania	12,151	6.2	4.9	-20.3%	Debate
Tennessee	5,524	6.5	4.8	-25.5%	No
3rd Quartile	Physicians	2010	2020	% Change	Expansion
Missouri	5,074	6.1	4.7	-21.7%	Debate
Kansas	2,315	6.2	4.7	-23.4%	No
North Carolina	7,803	6.3	4.7	-25.4%	No
Nebraska	1,481	6.0	4.7	-21.9%	No
Kentucky	3,490	6.0	4.7	-22.5%	Yes
South Dakota	708	6.1	4.7	-23.2%	No
North Dakota	595	6.1	4.7	-23.7%	Yes
Delaware	835	6.5	4.6	-28.2%	Yes
Louisiana	3,560	6.4	4.6	-28.5%	No
Texas	17,346	6.7	4.5	-32.2%	No
West Virginia	1,689	5.7	4.4	-21.8%	Yes
Oklahoma	2,813	5.6	4.4	-20.8%	No
4th Quartile					
Iowa	2,429	5.4	4.3	-20.4%	Yes
Montana	902	6.1	4.2	-32.2%	No
Alabama	3,579	5.4	4.2	-23.7%	No
New Mexico	1,778	6.5	4.1	-36.6%	Yes
Arkansas	2,227	5.3	4.1	-22.7%	Yes
South Carolina	3,579	5.7	4.0	-28.7%	No
Idaho	1,093	5.6	4.0	-29.3%	No
Mississippi	2,023	5.3	4.0	-25.5%	No
Wyoming	436	6.2	3.9	-37.5%	No
Nevada	1,950	6.0	3.6	-40.3%	Yes
Arizona	5,061	5.7	3.3	-43.3%	Yes
Florida	16,353	5.0	3.1	-37.6%	No
U.S.	277,440	6.9	5.0	-27.9%	

A more nuanced analysis adds additional context to these figures. Arizona's aged population (65-74: 56.5 percent of the total >65 years vs. U.S. 53.9 percent; 75-84: 31.8 percent vs. U.S. 32.4 percent; >85: 11.7 percent vs. U.S. 13.6 percent) will have fewer primary care physician resource demands than Pennsylvania's elderly population (65-74: 50 percent; 75-84: 34.4 percent; >85: 15.6 percent), where the likelihood of seeing patients with complex, co-morbid conditions is higher.

## Care extenders are not physicians

The average new patient wait time varies considerably by specialty and city.<sup>5</sup> Delays in seeing a physician are usually longest for primary care, and the new patient acceptance rate is also the lowest.<sup>6</sup> Care extenders, nurse practitioners and physician assistants are most suitable for lower clinical acuity and/or complexity patient. A registered nurse with a master's degree in nursing and 500 to 1,500 hours (15 to 40 weeks) of supervisory experience cannot compare to a primary care physician with four years of medical school and three to five years of post-graduate residency training.

## Medicare payment reform to accelerate

CMS has taken a leading role in reforming Medicare, and by default, the entire healthcare system. Medicare is often seen as the bellwether for reimbursement change by commercial payers. After several years of evolutionary changes, mostly voluntary but a few mandated, the U.S. Department of Health and Human Services (HHS) Secretary Sylvia Burwell made the following announcement on January 26, 2015:

"Today, for the first time, we are setting clear goals – and establishing a clear timeline – for moving from volume to value in Medicare payments... Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018. Our second goal is for virtually all Medicare fee-for-service payments to be tied to quality and value; at least 85% in 2016 and 90% in 2018."<sup>7</sup>

## Hospitals (health systems) investing in primary care

Since 2007, there have been 569 announced deals involving 1,144 hospitals.<sup>8</sup> According to the American Hospital Association, there are 4,974 hospitals in the U.S., implying that 23 percent of the total was involved in a transaction during the past few years.<sup>9</sup> The primary drivers for acquisition have been market share, scale and related operating efficiencies.

A recent study suggests that physician acquisition increases the likelihood that patients "will go to higher-cost, lower-quality hospitals."<sup>10</sup>

Hospitals and health systems are not only larger, but also more profitable. Operating margins, on average, have improved during the past few years from 4.8 percent in the first quarter of 2010 to 7.6 percent in the fourth quarter of 2013, an increase of 58.3 percent.<sup>11</sup> A bifurcation of financial performance is notable, with more than 1,500 hospitals, 32 percent of the total, having negative operating margins in 2013.<sup>12</sup>

Hospital and health system reach has also been extended via physician acquisitions. According to a survey conducted by Jackson Healthcare in 2014, 21 percent of physicians were employed by a hospital; another 14 percent reported being employed by a practice that is owned by a hospital or health system.<sup>13</sup> Primary care physicians are also being used to staff urgent care centers and serve as Medical Directors of retail clinics to increase access and build brand equity. Administrative hassle, lifestyle and a desire to "be a doctor, not a businessman" are the primary reasons for becoming an employee.

Two business models are driving primary care physician practice acquisition: the (self) *referral model* to ensure a high volume of acute care inpatients, emergency department visits and ancillary service utilization; and more recently, the *value-based model* focused on improving the efficiency and effectiveness of care delivery by keeping patients "healthy," while increasing system readiness for value-based reimbursement.

## Physician acquisition challenges, compensation and value

Physician acquisitions are not always successful. Network creation requires a clear geographic, specialty and service line strategy. Culture matters, especially during the transitional period from a smaller entrepreneurial practice to a larger established organization. System integration includes electronic medical records (EMR), scheduling, billing, e-prescribing, lab and other areas.<sup>14</sup>

In 1999, the Advisory Board stated "practice losses [by hospitals are] increasingly untenable."<sup>15</sup> The same thoughts are still being applied 15 years later to Medical Group Management Association (MGMA) data, albeit dated, to the median net loss per (acquired) full-time equivalent (FTE) physician: 2008: \$103,776; 2010: \$189,910; 2012: \$176,463.<sup>16</sup> However, unlike 15 years ago, the healthcare environment is dramatically different with consolidation throughout healthcare services, the availability of a hospital EMR infrastructure and the impending acceleration of Medicare payment reform.

The net loss calculation in hospital-owned practices is overstated based on arbitrary methodology. Net loss is a function of revenues (based on volume, payer mix and collections) and operating expenses (physician compensation, supplies and overhead: staff, rental, professional liability, IT allocation, management fees, etc.). At the time of acquisition, practice ancillary services are often transferred to the hospital, often leading to higher reimbursement.

Most provider organizations, especially hospitals and accountable care organizations (ACOs), use the Resource-based Relative Value Scale (RBRVS; relative value units per service code) developed in 1988 as a formulaic measure of physician (work) productivity and proxy for compensation. The American Medical Association assigns a relative value unit (RVU) to every work expense, practice expense and malpractice expense for approximately 8,000 Current Procedural Terminology (CPT) codes that are then adjusted (multiplied) by a Geographic Cost of Practice Index (GCPI). The sum total RVU is then multiplied by a conversion factor to determine the Medicare allowable payment. Price distortions, based on excessive use of survey estimates (practice expenses, physician time), have led to a significant reimbursement bias for procedure-driven specialties.<sup>17</sup>

The RBRVS approach does not consider the relative value of cost avoidance outcomes, such as preventable inpatient admissions for ambulatory case sensitive conditions, preventable hospital readmissions within 30-days of discharge and preventable emergency department visits. In addition, value-oriented activities such as care coordination and population health are not considered, and CPT codes for evaluation and management (E&M) developed more than 20 years ago no longer capture the complexity of managing patients with multiple chronic conditions.

#### **Bottom line:**

Primary care physicians have been increasingly recognized by CMS, hospitals, health systems and other providers as the linchpin of payment reform. Unlike procedural specialists generating revenues, primary care physicians generate (cost avoidance) savings through an increased focus on prevention, care coordination, site transition and self-management. A growing shortage will hinder the rate of transition by specific providers from volume (fee-for-service) to value.

Leading providers need to attract and retain primary care physicians with an increasing sense of urgency. A *value-based compensation system* is required for primary care physicians to facilitate and reinforce behavioral change. Continuing education could also potentially serve as an incentive, as an evidence-based and cost-effective understanding of newly introduced drugs and technology is essential to improve outcomes.

*Primary care redesign* is needed to enhance productivity, allowing for an expansion of panel size from an average of 2,000 - 2,500 patients to 3,000 - 3,500 patients. Patients need to be segmented based on medical complexity and acuity of need to facilitate the use of care extenders. EMR functionality can be used for patient segmentation, and the identification of care gaps, generation of cautionary flags and issuance of reminders to facilitate timely intervention.

*Technology*, if used appropriately, also represents another potential source of productivity enhancement. Telehealth networks are being established to provide increased access to patients in rural areas, as well as convenience to consumers. Remote monitoring technology is being increasingly utilized to facilitate early intervention in patients experiencing health crises, as well as to provide the consumers and their caregivers a sense of safety and security.

The concept of *co-accountability* needs to be strengthened between primary care physicians and medical specialists such as cardiologists (CHF), pulmonologists (COPD), endocrinologists (poorly-controlled diabetes) and gastroenterologists (Hepatitis C). Medical specialists have been trained in internal medicine prior to their fellowships and thus, if incented, are able to increase their practice mix to the management of complex, co-morbid primary care patients. Co-morbid depression in the elderly is often under-diagnosed and under-treated, creating an opportunity for co-accountability with psychiatrists and other behavioral health providers. Information transfer is essential to enhanced care coordination.

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<sup>1</sup> U.S. Census Bureau.

<sup>2</sup> MedPAC Data Book. Health Spending & the Medicare Program, June 2015.

<sup>3</sup> RWJF Chart Book entitled Chronic Conditions: Making the Case for Ongoing Care; February 2010. Sourced from Medicare Standard Analytic File, 2007.

<sup>4</sup> <http://www.modernhealthcare.com/article/20140719/MAGAZINE/307199981/specialists-see-little-change-in-compensation-survey-finds>

<sup>5</sup> <http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf>

<sup>6</sup> <http://www.massmed.org/News-and-Publications/MMS-News-Releases/MMS-Study-Shows-Patient-Wait-Times-for-Primary-Care-Still-Long/#.VKr7PivF9QE>

<sup>7</sup> HHS Press Office. Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting

Medicare reimbursements from volume to value; January 26, 2015

<sup>8</sup> Irving Levin Associates. The Healthcare Acquisition Report, 2015

<sup>9</sup> Fast Facts on U.S. Hospitals, American Hospital Association. (Article moved but retrieved from website on 9/25/2015)

<sup>10</sup> Kaiser Health News, Doctors more apt to admit patients to hospitals that own their practices, study says; September 10, 2015

[http://www.healthcarefinancenews.com/news/doctors-more-apt-admit-patients-hospitals-own-their-practices-study-says?mkt\\_tok=3RkMMJWWfF9wsRouuarjZKXonjHpfsX77%2BwsW6S1IMI%2F0ER3fOvrPUfGjI4JrcNjl%2BSLDwEYGJlv6SgFQ7LHMbpszbgPUhM%3D](http://www.healthcarefinancenews.com/news/doctors-more-apt-admit-patients-hospitals-own-their-practices-study-says?mkt_tok=3RkMMJWWfF9wsRouuarjZKXonjHpfsX77%2BwsW6S1IMI%2F0ER3fOvrPUfGjI4JrcNjl%2BSLDwEYGJlv6SgFQ7LHMbpszbgPUhM%3D)

<sup>11</sup> <http://www.healthleadersmedia.com>

<sup>12</sup> AHA Trend Watch Chart Book, 2015

<sup>13</sup> [http://www.jacksonhealthcare.com/media-room/articles/physician-trends/physician-data-on-practice-environment-workload-and-patient-access.aspx?utm\\_campaign=Physician%20Practice%20Environments%207.11.14&utm\\_medium=email&utm\\_source=Eloqua](http://www.jacksonhealthcare.com/media-room/articles/physician-trends/physician-data-on-practice-environment-workload-and-patient-access.aspx?utm_campaign=Physician%20Practice%20Environments%207.11.14&utm_medium=email&utm_source=Eloqua)

<sup>14</sup> HealthDirections.com

<sup>15</sup> [http://www.healthlawyers.org/Events/Programs/Materials/Documents/PHY12/papers/C\\_anning\\_deeson\\_slides.pdf](http://www.healthlawyers.org/Events/Programs/Materials/Documents/PHY12/papers/C_anning_deeson_slides.pdf).

<sup>16</sup> <http://www.modernhealthcare.com/article/20140222/MAGAZINE/302229986>

<sup>17</sup> Presentation. Thinking Differently About Payment for Primary Care: Why the Medicare Fee Schedule Needs Attention. Robert A. Berenson, M.D.; Institute Fellow, The Urban Institute, Robert Graham Center; 25 March, 2014

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