What's Ruining Medicine for Physicians: Imbalance in Primary Care Versus Specialist Reimbursement

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At the end of every year, Medical Economics publishes a list of the top challenges facing physicians. This list is generated by surveying our physician readers.

For this year's list, we decided to recast the question. Instead of asking what challenges physicians face, our editorial staff wanted to hone in on what issues annoy and frustrate doctors and get in the way of what's truly important: Treating patients and running practices.

And so we asked physicians in a poll: "What ruining medicine for physicians?"

In our list of the nine issues ruining medicine for physicians, the goal is not to dwell on the negative aspects of working as a physician. Instead, we wanted to show our readers that they share common challenges when dealing with the vexing issues facing primary care in today's complex healthcare environment. Each piece also offers practical solutions that physicians can start using in their practices today.

{Comments in curly brackets {} are mine.}

Note about Burnout

In our original survey, we included "physician burnout" as one of the issues ruining medicine. That garnered nearly 5 percent of responses, good enough for the 5th on our list.

But after further consideration, the editors and our medical advisers decided that burnout did not really fit, as burnout was a result of the challenges on or list. So we decided to leave it out. *Medical Economics* knows that addressing burnout is a top priority for physicians. We couldn't agree more, and will offer detailed coverage of physician burnout, including practical solutions, in upcoming issue so *Medical Economics*. Stay tuned.

{I left Prevea Clinic after 17 years due to burnout. I was working 83.5 hours per week, nights, weekends, holidays, etc. We often worked 4 days in a row without a day off. I worked in the clinic, the Emergency Department (ED), and the hospital. I worked in the Intensive Care Unit (ICU) as well. I could be called into the ICU at 2am on Sunday morning after working since Friday starting at 8:00 am. Then administration wanted to add Thursday evening and Sunday morning hours on top of current work-load. Then they added administrative burden on top of this. I reached a breaking point and left. Prior to my leaving, at least 3 colleagues left and a month after I resigned, one of my partners left. In my group of 5 physicians, we gained 2 but lost 4. The group went from a net of 5 to 3 and never recovered. It has been 13 years since I left, and they compensated by adding NPs.

In 1988 when I started, I could see between 18 and 27 patients a day. By the time I left in 2005, I was down to fewer than 15 patients per day. The effect is to reduce access to care to patients, effectively reducing physician manpower. Office visits at the time were about 20 minutes per visit. In 2018 they are at about 8 minutes per visit.}

1 Paperwork and Administrative Burdens

It's no surprise that physicians chose paperwork and administrative burdens as the top issue ruining medicine. Earlier this year, in the 2018 Medical Economics Physician Report, 79 percent of doctors said it was the top challenge they experience in practice.

Much of this burden is a result of changes in the last several years, notably the advent of value-based care.

Kevin Riddleberger, MBA, cofounder and chief strategy officer at DispatchHealth, which delivers mobile urgent care to homes, says paperwork or administrative duties is not the best use of clinicians' time and resources, and directly impacts patient care and increases physician burnout.

Kyle Varner, MD, an internist at the Tripler Army Medical Center in Hawaii and author of White Coat Cartels, laments that he spends more time in front of a computer documenting his time with patients than he actually spends with patients.

"This is not because I am trying to create a good record of the care—it is because I have to play semantic games so that the hospital gets paid," he says.

{In private practice, I had a single partner in Family Medicine. We had to meet Meaningful Use stage I requirements. We spend hundreds of hours on this task. We were reimbursed $18,000 for our efforts. We had 6 full time equivalent (FTE) employees. At en estimate of 400 hours, this amounts to $7.50 per FTE per hour, which is minimum wage. When it came to MU stage II, there were 37 requirements, about double the amount for MU stage I, and reimbursement was set at about $8,000. This manes twice the effort, we would get about $3.75 per FTE per hour. I estimated the effort was not worth it and took the 2% reduced claims fee. MU stage III was rescinded by the Center for Medicare & Medicaid Services (CMS) for lack of participation. Only 13% of practices met the requirements for MU III, which mostly involved computer interoperability. In effect, MU placed so many constraints on electronic medical record (EMR) systems that they became unusable, with too many prompts, and too many documentation requirements.}

Then when records come in from another hospital, often he must sift through hundreds of pages of data to find the important information he needs, saying it is hidden in a pile bureaucratically mandated auto-populated junk that no one wants to read.

{I have a photo that illustrates this. I photographed a very thick medical record in an Assisted Living Facility (ALF). The chart looked like 2 reams of paper, or about 100 pages, and it probably weighs about 10 lbs. In about 20 minutes I riffled through the chart and pulled out only those records that have clinical relevance. It was perhaps only 35 pages, or 7% of the total volume. The rest is for administrative and regulatory purposes, completely useless to me as a physician.}

Another challenge is dealing with insurance companies that try to convince him to prescribe certain drugs over others, citing a longer authorization process and lots of paperwork for his preferred choice in many cases.

"So, instead, I often adhere to their guidelines, which may not have the patient's best interests at heart," Varner says.

He cites the example of trying to get a Medicaid patient on sacubitril/valsartan (Entresto), a drug used to treat heart failure.

"I can expect to spend at least 45 minutes filing paperwork and I can expect to get multiple phone calls when I do this," he says. Because of the extra time needed, he feels Entresto isn't prescribed as much as it should be, blaming the indirect incentives created by third-party payers.

C. Nicole Swiner, MD, with Durham Family Medicine in Durham, N.C., says physicians are often in a tug-of-war between what is right for their patients' care, what the patient's insurance will cover and what the pharmaceutical companies will allow them to prescribe.

"Specialists are also still valued more than primary care providers, yet PCPs are underpaid and overwhelmed with work," she says. "I or my staff members spend the majority of our weeks on the phone and doing paperwork (often denied and resent having to do again) on our patients' behalf for better care."

Even students and residents can't escape busy work. Internal medicine residents spend just 12 percent of their time with patients and 40 percent on computer-related tasks or administrative tasks, according to a study out of The Johns Hopkins University School of Medicine.

Ways to overcome the challenge

There's no magic solution for eliminating paperwork or administrative burdens. But there are some ways physicians can ease the burden on themselves and their patients.

Have patients pay cash for medications: Varner frequently suggests that patients whose insurance company requires prior authorization take this route because it will simplify the process. "This is usually substantially cheaper than they think," he says. For example, when one of his patients was told by Medicaid that he couldn't have Linezolid without a pre-approval process, Verner got the patient a coupon so he could get the medication for just $50.

Rely on technology: Riddleberger says the future of healthcare operations and clinical delivery will improve thanks to enhancements to technology that will decrease paperwork and administrative burdens. Some of what's expected to help are increased

machine learning, natural language processing and artificial intelligence in day-to-day care delivery.

2 Difficulty Using EHRs

Physicians largely dislike their EHR systems and feel they are stuck with the ones they have, even when they are unhappy with it.

The Medical Economics EHR Report, published in October, found that 70 percent of physicians would like to switch systems but don't because of high costs and lack of better options. In addition, about 57 percent would not recommend their current system to a fellow physician.

These problems are leading many physicians to simply quit. The Doctors Company, a medical malpractice insurer, released a report earlier this year which found that 54 percent of physicians plan to retire within the next five year{s} because of burnout, with EHRs being a major contributor.

The report also revealed that 61 percent of doctors believe EHRs have a negative impact on efficiency and productivity and 54 percent feel they negatively affect the physician-patient relationship.

Richard E. Anderson, MD, FACP, chairman and chief executive officer of The Doctors Company, says there are two problems with EHRs. First, they require hours of duplicative and often unnecessary data input. Second, the systems are non-intuitive, vary widely, and don't communicate with one another.

"The experience in medicine has been that EHRs actually reduce physician productivity, and often impede rather than facilitate the care of patients," he says. "This is the exact opposite of what we seek when we deploy a new technology."

Christopher Maiona, MD, chief medical officer of PatientKeeper Inc., which provides financial applications to streamline physician workflow, says that based on 20 years of conversations as a hospitalist, EHRs generally confound and frustrate physicians.

"Problems include counterintuitive workflows, poor interfaces, bloated clinical documentation, and too many unhelpful alerts," he says in an e-mail. "It is sad but true that healthcare is the only industry which, in the course of computerizing its operations, has made its most valuable, highly compensated workers—physicians—less productive by increasing their administrative burden."

{I use OpenEMR from https://www.open-emr.org. It is freeware, essentially off-the-shelf technology, and is fairly easy to install and administer. I have all my data available to me on my personal server. I own the data! I can query against it and write computer scripts against the data, which saves me hundreds of man hours per quarter. I love my system. It is simple and unencumbered by many of the government regulations. It is ambulatory MU stage II. I have decided against upgrading since it would add too many useless modules which have been mandated by government sources. In short, keep it simple, stupid. Regulators just add complexity which is clinically unnecessary. For example, the last updated added a dialog box for any recently added items to the allergy list. However, every patient has the list in bold and red each time you open the patient's summary sheet. If I want to look at it, I do not need a pop up in my face to do so! I am forced to click to close it, which is a nuisance. What is worse is the system presented by Curo, to access my hospice patients. I use a portal to get into it, and the data is stored on a server in the cloud. Recent regulations require that I review the medications which each patient, which I do on my own. In order to document that I have done so, they force me into a process that takes 18 to 22 clicks to accomplish. This adds unneeded complexity to a process that should be simple. It now takes much longer to complete my documentation, with no added value. Forcing me into a laborious manual process does not make me think about the medications—on the contrary, it makes me ignore looking at the list in order to satisfy their requirement and get through my day. It has the opposite affect of making me ignore the list!}

Thoughts from users

John Nguyen, MD, chief medical officer at QueensCare Health Centers in Los Angeles, says for EHR use to become easier, providers should welcome feedback and be open to learning.

"An organization should be well-equipped with EHR specialists or equivalent positions to provide training as needed to all staff and providers," he says.

Maiona says every hospital and medical practice's goal should be to make EHRs a clinically indispensable tool for physicians to deliver optimal patient care. And that begins with improving EHR usability.

"In the mind of a physician, EHR usability refers to accessing and acting on patient information with ease. It's having data presented in a manner that is consistent with the physician's unique thought process and workflow, and that allows them to intuitively act on that information on the fly," he says. "It also means doing no harm."

Since hospitals have made huge investments in their EHR systems, Anderson says, they need to find ways to get the most out of those investments.

He says technology such as workflow applications, mobile device access, voice enabling tools and secure messaging apps assist in making things easier for physicians and therefore help in their use of EHRs.

Richard Schuster, DO, a family practitioner at Schuster Family Medicine in Indianapolis, Ind., says the problem with most EHRs is that they are not built to be health or medical records and are essentially billing platforms designed to extract data points.

"They are not designed to communicate or record effectively health or disease information," he says. "They do not tell the patient story, which is what the notes should communicate. They are difficult to use and time consuming to learn and manage."

Schuster believes the Affordable Care Act could have served to begin a conversation to identify the problems in EHR systems and seek solutions over time, but it wasn't.

"We need to sit down as a country, identify what our priorities and values are, and begin designing the system around those things," he says.

3 Government Regulations

When it comes to value-based care, government regulations often get in the way of physicians' best efforts and that's a challenge that irks many in healthcare.

Physicians told *Medical Economics* earlier this year that complying with government regulations was one of the top reasons their practice finances worsened in the last year. Many physicians also cited penalties from pay-for-performance initiatives as a reason.

Kyle Varner, MD, an internist and the author of White Coat Cartels, says under a value-based care system, physicians and hospitals face a penalty for caring for very sick or very difficult patients, because when reimbursement is tied to outcome, it is really tied to the demographics of the patient population.

"Low-risk patients will inevitably lead to higher reimbursement, and those who care for the highest-risk patients will end up being penalized," he says.

Richard E. Anderson, MD, FACP, chairman and chief executive officer of The Doctors Company, says the U.S. healthcare system isn't set up to accommodate new payment models, so the transition from where we are to where we are heading will be long and difficult. In fact, The Doctors Company's recent "Future of Healthcare" survey revealed high levels of resistance and skepticism among physicians when it came to value-based care.

"Healthcare is different from other industries. Human biology is almost infinitely complex and cannot be fixed on assembly lines," Anderson says. He believes the patient must be at the center of caregiving and there should be less concern of operating as if in a factory. The survey reflects that many believe endless regulations distract from patient care and waste physicians' valuable time.

Daniel Stock, MD, a family practitioner in Noblesville, Ind., says the problem with value-based care is that it isn't the patients' values that get reimbursed for, but rather whatever the accountant and his chosen "experts" value.

"To make matters worse, governments and insurers think that time spent cutting patients is more valuable than time spent thinking about patients, so they pay a premium for those services, which leads providers to recommend surgery over other treatment," he says. {Generally, procedures are valued over thinking. I remember doing ICU work, and discovered that spending 10 minutes adjusting a Central Venous Pressure (CVP) line and then evaluating the Chest X-ray paid more than spending 40 minutes going over a difficult patient with five comorbidities, reviewing the IV orders, their ventilator settings, their medications, and their plan of care. I would often interact with the nurses in the unit as well to get input regarding the progress of the patient, which is time consuming, and never compensated. Also, I can only bill for the morning visit, which means if I go back in the afternoon, that fee is already covered by the mornings activities, which means I could spend an additional 20 minutes with the patient and 30 minutes of commute

time without additional compensation. Doing the right thing does not get paid!}

The impact has been felt in the need for additional documentation and justification for services and payment. Moreover, each time another level of documentation is added, it takes time away from the patient encounter and from communicating with the patient or other physicians involved in caring for the patient.

Verner believes the best solution is to get the government out of the doctor-patient relationship.

"Healthcare policy should be laser-focused on giving consumers power and choices," Varner says. "Health savings accounts, healthcare cost sharing organizations, direct primary care and medical tourism are all viable solutions that can contribute to a revolution."

4 Prior Authorizations

Physicians hate prior authorizations. They find the process insulting, as they argue they know what's best for each individual patient under their care, and have the medical training and expertise to back up their clinical decisions. Prior authorizations also disrupt a practice's workflow by creating additional work for staff and physicians to get a treatment or test approved. Physicians also believe that prior authorizations are largely a cynical effort to shape treatment so as to contain costs and boost a payer's bottom line.

{According to *Medical Economics* metrics, the average primary care physician (PCP) spends 13.5 hours per week doing prior authorizations. I remember once being called by the hospital Electrodiagnostics department. The technician on the other end of the line stated that I needed to get a prior authorization for an echocardiogram on one of our patients. I said, "why is that my responsibility? Who is getting paid for this echo? The money goes to you, not to me. Why don't you do it?" She said, "because you are the ordering physician, and you have the clinical data." I said, "why don't you ask me the clinical reason, and you can call the insurance company, spend 20 minutes on the phone and respond to faxes, and get the approval."}

"[Prior authorization] has nothing to do with medical care," Kenneth Kubitschek, MD, an internist in Asheville, N.C., told Medical Economics earlier this year. "It's all about saving money and putting people through the hassle so they get tired of the hassle."

These sentiments are backed up by data. More than three out of four physicians (78 percent) say prior authorizations were the most challenging issue they experienced when dealing with payers, according to the *Medical Economics 2018 Payer Scorecard* survey. Furthermore, physicians said they and their staff spend upward of 20 hours per week, on average, dealing with prior authorization issues.

"We want to take care of the patients, but we're taking care of the insurance company," said Ripley Hollister, MD, a family physician in Boulder, Colo., and a board member of the Physicians Foundation, which advocates on behalf of practicing physicians.

Furthermore, physicians are pessimistic that there's anything they can do, either individually or collectively, to make prior authorizations go away. Still, there are strategies doctors can put in place to better manage prior authorizations.

Focus staff efforts

Find a staff member that can focus on prior authorizations, Kubitschek said. This person can attempt to monitor formulary changes, track prior authorization requests to detect patterns and eliminate inefficiencies.

Get patients involved

There's nothing wrong with having patients assist with the prior authorization effort. One way payers get away with prior authorizations, Kubitschek said, is that they often don't involve patients. Asking patients to call their insurance company to inquire about prescriptions and tests is one way to make patients a part of the process.

Play hardball (when possible)

Do you have a payer contract that's given you a lot of problems? Consider not re-upping with that payer. Kubitschek said this is not a decision to make lightly, as it affects patients under your care. But sometimes the extra work and headaches are just not worth it.

Go direct pay

One radical solution is to stop accepting insurance at all, and go with a direct primary care model, Hollister said. This requires careful thought and meticulous business planning, and should not be done haphazardly. However, switching to a direct model is an option worth considering.

Advocate

Physicians often are leery about getting involved in politics. But it is one way to bring about change. David O. Barbe, MD, MHA, the former president of the AMA, told *Medical Economics* earlier this year that physicians can work through their state medical societies and other membership organizations to fight for change.

"These membership organizations exist to serve their members and patients, and they want to hear from practicing physicians about obstacles they face in providing high-quality care," Barbe said.

5 Replacing Primary Care Physicians with NPs/PAs

The number of new nurse practitioners (NPs) and physician assistants (PAs) continues to out-pace the number of new physicians nationwide, causing some concern among primary care doctors. There are more than 248,000 NPs currently licensed to practice in the United States, up from about 120,000 in 2007, according to the American Association of Nurse Practitioners. An estimated 85.5 percent of new graduates have been trained in primary care.

Similarly, the number of physician assistants has grown exponentially, from just four in 1967 to more than 115,000 in 2018, according to the American Academy of Physician Assistants. Slightly more than 30 percent of PAs work in family medicine.

Both professions are projected to grow more than 30 percent by 2026, creating frustration among doctors who fear being replaced by lesser-trained professionals in providing primary care.

{According to www.ahrq.gov, there are 246,000 primary care physician (PCP) in the U.S. The rate of growth of PCP is only about 2.2% per year, outpaced by NPs and PAs growth at 3.75% per year (30% divided by 8 years.}

"One of the biggest concerns we have is the development of diploma mills—NPs in particular are being churned out of online programs," says Rebekah Bernard, MD, board member of Physicians for Patient Protection, an advocacy group for physician-led healthcare.

She adds that there is no standardized education for NPs and PAs, so knowledge and training can vary widely among graduates. "The gap in required education is staggering—physicians aren't allowed to practice until we have trained for about 20,000 hours, while NPs may have 1,000."

Yet NPs are often promoted by health systems and nursing programs as being "just as good" as doctors and are now allowed to practice independently in 23 states.

The push for more non-physician providers in primary care is coming not just from healthcare organizations looking to reduce costs, but from patients who want more convenient access to providers. These patients often lack respect for the amount of training it takes to be a physician and want instant answers and quick care, and a nurse practitioner at a retail clinic can often provide that, even though it may incur a higher risk, says Bernard.

"The biggest thing with a new NP is they don't know what they don't know," she says. "They don't have the experience, and really don't realize how quickly something can go wrong."

Doctors working for health systems can be assigned supervisory duties over non-physician providers who may or may not have appropriate training, putting physicians who are already short on time in a position of having to assume liability for supervising them.

"There's no oversight on hiring or how helpful they might be, but doctors are expected to supervise them or they'll be let go," says Bernard. "Physicians should be extremely aggressive if doing true supervision and not just sign off on charts. Understand their knowledge base and there should be true collaboration."

Bernard says collaboration is the key. Laws should limit what NPs or PAs can do on their own, and they should always have to work under the supervision of a physician.

6 No Negotiating Leverage with Payers

Negotiating contracts with payers has always been an unpleasant task for doctors. But it has become even more difficult in recent years, thanks to trends such as value-based care and consolidation among commercial payers.

"The big payers don't want to negotiate with small practices. They say 'take it or leave it,'" Rebecca Jaffe, MD, owner of a Wilmington, Del. internal medicine practice, told *Medical Economics* in 2013.

David Zetter, CHBC, founder and lead consultant of Zetter HealthCare in Mechanicsburg, Penn., notes that until about a decade ago many payers would give small increases to doctors in their networks without asking for much evidence that the providers were improving outcomes or holding down costs. But no longer.

"Healthcare financing is getting tight and payers want to increase their profits," Zetter says. "In addition, with everything going to value-based, the payers are getting more sophisticated. They're demanding more information and evaluating providers on a more rigorous basis." Evidence of that, he adds, is the trend of payers narrowing their networks to include only those physicians and practices demonstrating the lowest costs and best outcomes.

For doctors, this new reality means they need to become more sophisticated and proactive in their approach to contract negotiations. A good place to start, Zetter says, is by understanding the payer's perspective. Most contract managers operate with a fixed budget, so increasing one doctor's reimbursement means reducing payments to another. "There needs to be a win-win situation for it all to come together," Zetter explains.

With that in mind, Zetter says, physicians need to ask themselves, "What can I do for the payer that's going to make it [raising reimbursements] a benefit to them? Is the issue that my costs are too high? Am I referring patients to specialists that don't have good outcomes?"

Zetter also recommends that doctors participating in Medicare's Quality Payment Program obtain their quality and cost data (available at https://qpp.cms.gov/participation-lookup). That information will help level the playing field when negotiating with commercial payers, most of whom have their own data about the doctors in their networks —but may not be sharing it.

"If they have a provider with low costs and good outcomes, and yet are underpaying them compared to other providers in the same specialty, they're getting a good provider on the cheap," he explains. "So the doctor who's going to negotiate with them needs to let them see how good a practitioner they are.

"Doing your homework means a better chance of success in getting what you want, versus just saying 'I want to negotiate a new contract,' because in most cases now that won't get you anywhere," Zetter adds.

Along with preparation, regular communication with payers is helpful for ensuring successful negotiations, says Lucien Roberts III, FACMPE. The administrator of a Richmond, Virginia gastrointestinal practice, Roberts has negotiated contracts with many of the country's largest commercial payers. He makes a point of contacting representatives of his major payers several times a year.

"I found it's a lot more effective to negotiate with someone you have a relationship with than being a stranger coming in with a demand for more pay," Roberts told *Medical Economics* in 2015.

"Even if all they do is say 'everything's fine with your practice,' when it comes time to talk about a new contract you can say 'look, we've been talking for two years and you've said things are fine here.' It takes the element of surprise off the table."

7 Rising Staff and Overhead Costs

Every business grapples with rising employee and overhead costs, but these increases are particularly distressing for physician practices. Since 2013, the median operating costs for primary care practices rose by 13 percent {or 2.6% per year, roughly the rate of inflation}, according to a 2018 Medical Group Management Association (MGMA) report.

"What I think has made it more acute and painful for physician practices is that earnings have remained fairly flat," says Susanne Madden, president and CEO of The Verden Group, a practice-management consulting firm in Nyack, N.Y. "We're not seeing insurance companies increasing payments to providers that keep pace with their burgeoning expenses."

To combat these rising business costs, practices must balance reducing expenses with driving revenue growth. Here are four strategies that can help practices succeed in the face of financial constraints.

Find the best vendor contracts

Get the best prices for medical and office supplies, medications, vaccines, and other overhead services by taking advantage of discount contracts. These contracts are easy to find with a bit of research and can be secured independently or through group purchasing, but it's important to stay abreast of what's available, says Deborah Winiger, MD, a solo family physician in Vernon Hills, Ill. "I was discussing vaccines [with another physician] and he was paying $50 more a dose [than I was] for one shot, and he had no idea."

Expand practice offerings

Ancillary services can improve the bottom line but often require considerable upfront investment. If a practice is not financially ready to add an ancillary service, Madden recommends renting out practice space to complementary specialties and/or offering educational sessions on pertinent topics, such as mental health or nutrition, that patients can attend for a modest fee. These offerings require minimal investment while providing value for patients and a revenue boost for the practice.

Invest in staff

Administrative and clinical staff members play a pivotal role in the success or failure of a practice, and employing non-physician providers leads to increased revenue despite greater expenses, according to the 2018 MGMA report. Therefore, it pays to hire and retain skilled and engaged employees, even if that means offering them competitive wages and benefits. "You want to make sure you can attract the good ones," Madden says. "[If you don't] it hurts you in so many ways—from patient frustration with a person who doesn't know what they're doing up front to the physicians not being adequately supported in their clinical work."

Solicit patient feedback

Don't rely on trial and error to pinpoint which areas of the practice are functioning well and which need improvement, as decisions based on incorrect assumptions can be expensive to rectify. "Ask your patients," Madden says. "You have a focus group coming through your doors every day that you're open." She suggests utilizing check in to survey returning patients on potential practice changes, such as additional appointment times or new services. Similarly, check out provides the opportunity to inquire about and address any issues patients may have experienced during their visits.

Asking patients what they want from the practice is key to improving patient satisfaction, which increases the likelihood of retaining current patients and acquiring new ones without any additional marketing costs. "My practice has been built on loyalty of patients. A lot of my patients have been with me the whole time, and they refer their friends and coworkers," Winiger says. "Be good to your patients and be a good physician. That brings patients in and helps the bottom line."

8 Imbalance in Primary Care Versus Specialist Reimbursement

Primary care pay has increased by more than 10 percent over the past five years, nearly double the rate of specialist compensation during the same time period, according to data from the Medical Group Management Association (MGMA). {This has not been my experience. In 2005 Medicare paid about 34 cents on the dollar and in 2018 it pays about 29 cents on the dollar, based on usual and customary fees.}

But even with these gains, primary care physicians earned a median income of $257,726 in 2017—compared with a median of $425,136 for specialists. {You can only make $250k if you work 84 hours per week, and that is in areas where the cost of living is high such as New York City or Chicago. I have never made more than $156 in a given year, which was around 1996.}

The discrepancy in reimbursement between cognitive and procedure-based specialties has never been a secret. "Doctors don't choose careers in primary care for the money or the lifestyle," says Heidi Larson, MD, a consultant with Stroudwater Associates. "We

choose it for the relationships with patients and their families," says Larson, who spent the first 15 years of her career in solo family practice in Portland, Maine.

But owning and running a practice on relatively little income exacts a toll on precisely that element of practice, as physicians are forced to spend less time with more patients, she says. "It's not just about the disparity in reimbursement. It's about the loss of relationship and face-to-face time with our patients."

It may not be feasible to eliminate the disparity altogether, but Larson predicts that continued movement away from fee-for-service reimbursement and toward global payments will alleviate the strain on primary care practices.

"We need to change the payment model to incorporate care management fees and incentives for quality, cost, and utilization. And I think that's going to become more obvious in the coming years," she says.

In the meantime, primary care practices can optimize their reimbursement at current rates by implementing team-based care, a staffing model in which all clinicians work to the top of their licensure, Larson says.

The MGMA report reflects an increase in team-based care by noting significant growth in compensation for non-physician practitioners. {This needs to be doubled. For privately insured patients, I get on average $77 per patient encounter, but to cover my costs and make an income, I need to charge $130 per patient encounter.} "In many communities that we visit, nurse practitioners and other advanced practice providers provide immediate care and same-day access," says Nick Fabrizio, a principal consultant with MGMA.

When working with clients to redistribute their workload throughout an established team, Larson tracks measures such as patient experience scores, capacity and access, quality metrics, cost and utilization, and provider satisfaction before implementation of team-based care and again at three, six, and 12 months.

Success in these measures not only ensures clinicians' and patients' acceptance of the model, but can also help optimize reimbursement.

For example, high-performing teams can help fill gaps in care by teeing up and ordering routine health maintenance, prescription refills, smoking cessation, advanced care planning, and other items that factor into coding and reimbursement, she says.

9 MOC Costs and Requirements

{This is one of the biggest scams in medicine. CME is every 2 years and recertification is every 10 years, costing thousands of dollars per year and lot of time spent away from medicine and family. Time spend out of the office just amplifies the cost.}

Physicians have numerous complaints about maintenance of certification (MOC), with its significant commitment of physician time, effort, and financial expense ranking near the top. In that context, primary care physicians' perception that much of the information on which they are evaluated is irrelevant to their daily practice amplifies their frustrations.

A recent survey from MDLinx garnered powerful comments from physicians. One respondent wrote: "This is a ridiculous, time-consuming, family-wrecking, practice-interfering, sleep-depriving activity that leads me to want to quit [medicine]."

According to the survey, 62 percent of respondents who took the 10-year exam spent more than three months preparing, while 33 percent of those who chose the Knowledge Check-In exceeded three months of study. Both formats are "open book," meaning that physicians have access to clinical decision support while taking the assessment.

Meanwhile, 65 percent of physicians who responded to the survey reported that the MOC process added no clinical value to their practice of medicine. Some even argued in their comments that it causes harm. As one respondent wrote: "I found the whole exercise devoid of value, tedious, emotionally taxing, and disruptive. I am a rural physician and travel was required for this exam. MOC significantly contributes to physician burnout and office interruption."

"It's clear from the physicians' responses that preparing for MOC adds to their burnout," says Sarah Anwar, director of content strategy for MDLinx.

What's more, the financial requirements of MOC spelled out by the American Board of Internal Medicine (ABIM) and American Board of Family Medicine (ABFM) on their websites do not include costs related to travel or lost practice time.

Although MOC is not required in all states, it's not unusual for hospitals or insurers to mandate that

their physicians participate in the program. And in the age of increasingly consumer-directed healthcare, patients frequently use the American Board of Medical Specialties' (ABMS) website to verify physicians' board certification or ABMS MOC, says Marianne Green, MD, a board-certified internist who is a member of the ABIM Board of Directors and the ABIM Council.

From that perspective, physicians may receive a return on their investment in MOC. "But the most important reason [to pursue MOC] is our professional obligation to serve patients as best we can," says Green, who is also an associate professor of medicine and medical education and senior associate dean for medical education at Northwestern University Feinberg School of Medicine.

Nonetheless, she sympathizes with the plight of primary care physicians. "The challenge of being a primary care physician has risen exponentially in the last few years, given the complexity of what we see in our patients, the amount of things we need to do for our patients, and the evidence explosion of the science," she says. "I understand why physicians are trying to cut [burdens] where they can, but this is not an area where we can cut. It's critical that we have external assessments that help us understand what we don't know."

ABIM has also made a concerted effort in recent years to ease the MOC process, she says. For example, many physicians don't realize that ABIM has a relationship with the Accreditation Council for Continuing Medical Education (ACCME), under which physicians can get MOC points by performing certain CME activities, "You can hit a button on the UpToDate site and submit those points for MOC seamlessly," Green says.

The ABFM has also announced it will pilot a new MOC option in 2019, in which diplomats will receive 25 online questions each quarter. Not only will family physicians who choose the alternative test be able to take it at the time and place of their choosing, but they will be allowed to use clinical references to answer the questions.

{Due to the loss of autonomy of physicians and the loss of compensation and the increased administrative burden, in the 2010s I have discouraged my children from going into the field of medicine. This is in stark contrast to my father as a physician in the 1980s doing the opposite with my brother and myself.}

Ref: http://www.medicaleconomics.com/article/whats-ruining-medicine-physicians-imbalance-primary-care-versus-specialist-reimbursement