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- Ongoing news and in-depth reporting on MedicalEconomics.com. We also have created a COVID-19 page, where you can find all of our coverage at: MedicalEconomics.com/coronavirus.

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Medical practices reel financially from COVID-19 losses

by KEN TERRY Contributing author

A

merica’s physician practices face devastating financial losses due to the COVID-19 pandemic. What will happen long term is unclear, but doctors and observers say the actions taken so far by the government to support practices are inadequate and that more needs done.

Currently, physician practices are experiencing 30% to 75% decreases in patient volume, says Halee Fischer-Wright, M.D., president and CEO of the Medical Group Management Association (MGMA) headquartered in Englewood, Colorado. The business of primary care practices is down 40% to 50%, she says.

The situation would be even more dire if not for telehealth and the new willingness of the Centers for Medicare & Medicaid Services (CMS) to cover virtual visits. “Since CMS changed their regulation of reimbursement, we’ve seen telehealth enthusiastically embraced across the country, to the point where it has become an integral part of care delivery just in the [past] three weeks,” Fischer-Wright says.

Nevertheless, many small, independent practices are having difficulty ramping up telehealth systems and workflows. Even if they can master this technology quickly, most small practices have no more than two or three months of operating expenses in reserve, notes Medhavi Jogi, M.D., co-owner of Houston Thyroid & Endocrine Specialists, a five-physician group practice. At some point, unless the crisis ebb fairly soon, many independent practices will have to consider reducing physician compensation and/or laying off staff to survive.

Some practices may not survive. “Without immediate governmental action, practices around the country will fail,” wrote Jeff Livingston, M.D., CEO of MacArthur Medical Center in Irving, Texas, in a recent opinion piece. “The U.S. will be faced with an unprecedented crisis of unemployed physicians right at the potential peak of the COVID-19 pandemic.”

SYSTEM-OWNED VS. INDEPENDENT PRACTICES

Physicians employed by health care systems are in better financial shape than independent doctors, at least for now. For example, internist Jeffrey Kagan, M.D., recently joined
Hartford HealthCare, a large system based in Hartford, Connecticut, after many years as an independent practitioner. Kagan became part of Hartford on Feb. 3, just weeks after the first confirmed U.S. case of the COVID-19 virus.

Kagan is grateful he made the move when he did. “It couldn’t have happened at a better time,” he says. “With the decreased volume of patients we’re taking care of, I’m still able to get my salary. Otherwise, I don’t know whether I could keep my staff and overhead going.”

Another advantage: The system immediately got Kagan up on its telehealth platform, enabling him to conduct virtual visits with many of his patients. He says he doesn’t know whether he could have made the transition to telehealth as well on his own.

Kagan is still seeing patients with urgent nonrespiratory issues in person but is taking care of other patients via the telehealth app in the patient portal of Hartford’s electronic health records. Still, his appointment volume is down 50% to 60%. On a typical day recently, he saw three people in the office and eight via telehealth.

**PAY CUTS AND LAYOFFS**

Yul Ejnes, M.D., is an internist with Coastal Medical, the largest primary care group practice in Rhode Island. Unlike Kagan, he can’t count on a fixed salary. As one of the physician owners in the 125-provider Providence-based practice — which bases compensation on productivity — Ejnes realizes the reduced volume he’s experiencing will eventually require him to take a pay cut.

Ejnes is still working in his office but is doing mostly virtual visits. “We’ve converted our regular daily schedules to telehealth — either audio-video or telephone,” he says. “Our organization has been able to set up a couple urgent care clinics for people who really need to be seen. We’ve segregated that into respiratory/sick visits and nonrespiratory/sick visits. We haven’t been able to reach some patients to tell them their office visits are being turned into telehealth visits, and they’ve come in. I saw one [in-person] patient this week, and [every-one] else has been [seen] remotely.”

Ejnes says he is now seeing two-thirds as many patients as he saw before. Of the 12 virtual visits he conducted recently, five were audio-video and seven were via phone.

For people with respiratory complaints, he manages them virtually if they’re not too ill. If they’re too sick to manage virtually but not ill enough to send to the emergency department, he refers them to the group’s respiratory urgent care clinic.

The group hopes to avoid layoffs, but private practices generally aren’t bringing in enough revenue to make payroll, Ejnes says. Some of his office’s medical assistants are working from home because patients are not coming into the office. Even with virtual visits, administrative tasks such as managing lab results and handling correspondence and forms have decreased significantly.

“There are other needs that are new, such as transitioning people from in-person visits to telehealth visits and teaching or guiding them [to install the apps],” Ejnes says. “But the overall result is that there might be a decreased need for support staff. And the possibility of furloughs is definitely an option.”

**SMALL PRACTICES FACE THREATS**

Jogi, the Houston endocrinologist, says his practice switched completely to telehealth in late March and sent all of its staff home. But it’s still unclear how long the practice will be able to survive in its current form, Jogi says.

Unlike many small practices, which have been reluctant to embrace telehealth, Jogi and his colleagues have been conducting virtual visits for the last five years. About 30% of Jogi’s visits were virtual even before the pandemic. Although virtual visits comprised a much smaller percentage of the other doctors’ visits before, “they all knew how to do it, and the systems were in place,” he says.

The practice has halted in-office procedures, such as thyroid biopsies and thyroid ultrasounds, because Texas banned all procedures at least through April — another financial hit for the practice. In addition, Jogi notes, many patients with diabetes and other metabolic disorders are afraid to go to procedures at least through April — another financial hit for the practice. In addition, Jogi notes, many patients with diabetes and other metabolic disorders are afraid to go to Quest Diagnostics or LabCorp for testing. That has reduced patient volume because there’s not much to talk about with these patients in the absence of recent lab results.

The cash flow in Jogi’s practice has not dropped off yet because payments from claims filed weeks ago are still coming in. But he and his two partners (the other doctors are employees) are keeping a close eye on their bank statements. “Once we start seeing the daily [electronic] check deposits...” --HALEE FISCHER-WRIGHT, MD, PRESIDENT, MGMA
Where can practices get financial help?

Private practices that are or think they will soon be in a financial bind because of the COVID-19 crisis have some options. For starters, they can get a bank line of credit to cover expenses for a few months.

"Many practices are going to banks to extend their lines of credit, which have become much more flexible," says Halee Fischer-Wright, MD, president and CEO of Medical Group Management Association (MGMA). "With the interest rates close to zero, banks want that kind of business."

Under the recently enacted rescue legislation known as the CARES Act, businesses with fewer than 500 employees can access $349 billion in loans from the U.S. Small Business Administration (SBA). The low-interest loans, available through June 30, are designed to cover up to eight weeks of payroll costs and can also be used to pay mortgage interest, rent and utilities.

An SBA loan can be forgiven if a business uses at least 75% of the money to cover payroll. Otherwise, the money must be repaid within two years. Loan payments are deferred six months.

The CARES Act also authorizes CMS to expand its Accelerated and Advance Payment Program, normally designated for natural disasters. Qualified physician practices can apply to their Medicare Administrative Contractors (MACs) for an advance payment of up to three months’ worth of their historical Medicare reimbursement. The payments will be issued within seven days of the provider’s request, according to CMS.

For 120 days after the payments are issued, practices can continue to bill Medicare and be reimbursed for their services. At the end of that period, CMS will begin to recoup the advance payments by subtracting them from new Medicare claims until they are repaid.

Some observers are skeptical these actions will be sufficient.

"This is a half-measure, in my opinion," says Yul Ejnes, MD, an internist with Coastal Medical in Cranston, Rhode Island. "All this does is stop the financial hit that will result from COVID-19, which will occur at the time of recoupment instead of right now."

Fischer-Wright agrees. "If you’re trying to make your practice work today, if you’re under the gun, the CMS program allows advance payments that you can receive in seven days. That’s the tourniquet on the arterial bleed," she says, adding that MGMA, the American Medical Association and the American Hospital Association are lobbying Congress to remove the repayment feature of these loans.

Meanwhile, CMS recently made another rule change that should significantly help practices that now depend on telehealth revenues. When CMS allowed Medicare to cover telehealth visits from any location in any area of the country during the COVID-19 emergency, it restricted full reimbursement to audio-visual visits and kept phone encounters limited to $15 per visit. In late March, however, CMS said it would start paying for telephone E/M services (CPT codes 99441-99443) as a telehealth service. According to Ejnes, the payments have been set at a level between office-based E/M codes and the old telephone rate.

As long as the group can keep telehealth volume up, he adds, he doesn’t think they’ll have to let the employed doctors go. "But it will probably tank at some point, and we’ll have to ask for concessions. If they’re not willing to concede, there may be layoffs."

LONG-TERM OUTLOOK

Observers expect that most independent practice leaders will delay layoffs for now.

"The sequence is often that practice owners take home less money," says Joshua Halverson, who holds a master’s in both public health and health administration and is a principal at ECG Management Consultants. "I’m not hearing people talk about big layoffs of clinical staff. There are a lot of people still hopeful that this is a temporary — month or two — situation and [that] people can hold off...

Fischer-Wright of MGMA says that layoffs carry costs, which can include an increase in an organization’s unemployment insurance tax rate. "More often than not, it’s better to keep people furloughed [than to lay them off]," she says. "It’s probably better in the long run, if you have good staff, to furlough the staff.

"At the same time, I’m seeing practices that are using this crisis as an opportunity to separate staff that are less than optimal."

Planning how to deal with staff and other overhead costs depends on how long the crisis lasts and how severe it is in a practice’s geographic region, Fischer-Wright says. MGMA forecasts that the crisis will continue for at least another three to four months and possibly longer.

"Practices should be reasonable about expectations for their volume and how long this downturn is going to last," she says. "If you’re a primary care practice, this is probably a six- to eight-week period in which you can count on volumes being down 50% to 60%. Then you can figure another four to six weeks while that volume builds up, when your volume is down 20% to 30%. Then you’re going to have to expect your volume to be only 80% to 90% of what it was for the rest of the year. It’s not going to be 100% because there will be high-risk populations who shouldn’t be in the office environment until we have an effective vaccine and treatment available."

drop, we know we’re going to have to change some staffing," he says.

Assuming the group can keep telehealth volume up, he adds, he doesn’t think they’ll have to let the employed doctors go. "But it will probably tank at some point, and we’ll have to ask for concessions. If they’re not willing to concede, there may be layoffs."

As long as the group can keep telehealth volume up, he adds, he doesn’t think they’ll have to let the employed doctors go. "But it will probably tank at some point, and we’ll have to ask for concessions. If they’re not willing to concede, there may be layoffs."
Creating a strategic plan and thinking strategically are not about doing more. They are about focusing how you spend your time so that you are more effective in reaching your goals and getting to where you want to go.

That said, no physician practice has an unlimited amount of time, money or resources. Strategic planning can help you make the most of the resources you have, allowing you to have more enjoyment in your work while you are doing it.

Here are eight reasons for getting your team together for a strategic planning session.

1 **Vision**

You will create a clear vision for what success looks like in the future. If you don’t know where you’re going, how are you going to get there?

2 **Priorities**

You’ll identify priorities for the short and medium term. You can’t do everything at the same time, so focus on what needs to be done now and then do it well.

3 **Alignment**

You’ll get alignment and buy-in on direction and strategy. Having these conversations will move your team from implicitly being on the same page to explicitly being on the same page. The clarity will energize the whole team.

4 **Identify Challenges**

You’ll create an opportunity to talk about key issues facing the business (competition, changing trends, etc.). You want to ride the waves, not get smashed by them. Being reactive throws off your plans and takes your eye off your goals.

5 **Direction**

You’ll create a clear road map for the rest of the organization. Your staff wants to know where the practice is going and how they can contribute. An engaged staff is 20% more productive than one that is neutral (or, worse, disengaged). Your staff wants to win and this is how you can help them.

6 **Open Communication**

You’ll create space for people to share what’s going on with them and what they want to see as the future of the organization. It will open lines of communication and improve teamwork.

7 **Empowerment**

You’ll empower others to take on tasks that will move the practice forward. As a physician owner, that means less firefighting and more focusing on what you do best: patient care, leading and executing.

8 **Values and Culture**

You’ll create the culture, values, and behaviors that you want to foster within your practice. When your values are clearly articulated, your team will understand what you expect from them on a day-to-day basis. Culture and values are the glue that keeps a strategic plan together.

Strategic planning doesn’t need to take a lot of time away from the practice. The focus and the results will speak for themselves.

Before the COVID-19 outbreak, we conducted many strategy discussions with physicians onsite. Recently, we have shifted to doing these discussions virtually. They key is to have an outsider facilitate the meetings to avoid confirmation bias. Furthermore, the facilitator will be able to ensure your meetings stay focused, allow everyone time to share their thoughts, and ultimately leave you with a clear plan on how to move forward.

Medical practices which consistently apply a disciplined approach to strategic planning are better prepared to evolve as the local market changes and as the healthcare industry undergoes reform. The benefit of the discipline that develops from the process of strategic planning also leads to improved communication. It facilitates effective decision-making, better selection of tactical options, and leads to a higher probability of achieving the physician owners’ goals.

Nick Hernandez, MBA, FACHE, is the CEO and founder of ABISA, a consultancy specializing in strategic health care initiatives for physician practices. Send your practice management questions to medec@mjlifesciences.com.
Patients with complex conditions require a multidisciplinary effort to optimize care and control costs. Care coordination is the goal, but getting there can be a challenge. What role should primary care physicians play in this process, and how can they do it without neglecting their patients? Experts provide insights below.

THE PRIMARY CARE PHYSICIAN: LEADER OR BYSTANDER?

Care coordination takes a team that involves physicians, case managers and ancillary caregivers. Outlining the physician's role can be difficult, though, as the current system does not provide physicians with the time or compensation to thoroughly manage the ongoing care of patients with complex chronic diseases.

Sarahjane Rath, M.P.H., CHES, a trainer and curriculum development specialist for the health care policy and advocacy firm Primary Care Development Corporation, says while primary care physicians are important to the care coordination process, they should not be the process's point person. "Their role is never going to be huge because they have such a time limitation. They really can't spend that extra time with the patient," she says.

Rath, who helped develop a weeklong, face-to-face training program on care coordination for physicians, pharmacists and other frontline caregivers, says physicians should focus on their strengths and let the care managers and other service providers carry on care management work. This includes following up with patients and managing ongoing lifestyle issues. If physicians have an understanding of what care management is and an understanding of the topics that it addresses, they will be more inclined to solidify and endorse the referral system so it falls not just on themselves but also on other caregivers, she says.

A good referral system is a strong foundation, and it isn't limited to medical specialties. Physicians should make appropriate referrals to specialists as well as case managers and social or community service agencies to help patients meet their goals. If they instead take on that care themselves, they take time away from providing medical care, and that's where they are really needed.

Many physicians say they simply don't have time to address care coordination,
Chronic Conditions

Mastering care coordination

Rath adds, “This is where face-to-face training on what care coordination is and who takes on what role in the process is ideal. Physicians and other caregivers can discuss the process openly and address issues and (identify) problems in the cycle. A dialogue is helpful among all the disciplines,” she says. “They need to understand the process of case management and acknowledge that it takes a team to address chronic disease. It’s not just chronic disease management; it’s the whole picture.”

A physician is key to diagnosing and developing a treatment plan, Rath says. It’s all the rest that they really can’t, or shouldn’t, take on. Making sure patients have access to their medications and glucometers, a ride to appointments, and help with making diet and lifestyle changes, improving health literacy and addressing social determinants of health — these are all time-consuming yet very important elements of chronic disease management.

“It really does take a village to look after a patient, so in turn, it takes a team to look after a patient,” Rath says.

Physicians have to keep in mind their role in the care coordination cycle, however, and problems in the cycle should become the job of them team to resolve. A case manager or advocate is best served as the point person for each patient and can see where things fall through and work with the team to address issues. A primary care physician who sees patients returning over and over again for the same issues is a sign that the cycle is broken, Rath says. At that point, a physician should make a referral to social and case managers to identify the problem in the cycle.

While this may seem like passing the buck, Rath says, this is where the open dialogue and training come into play.

“The physician needs to just do a referral here or there. The physician should know whom to refer to for the problem or barrier,” she says. “Having physicians in these face-to-face training sessions is invaluable because it helps them to understand their role.”

A MATTER OF OPINION OR FACT?
The notion of giving up the role that is the primary care physician’s namesake — as the primary clinician — can be difficult to resolve.

Samuel “Le” Church, M.D., M.P.H., a family physician in Gainesville, Ga., says while it’s true that primary care physicians are pressed for time and reimbursement to support care coordination, it’s also a critical part of their role.

“Good care coordination can’t be the responsibility of a given doctor. It’s the responsibility of a care team. That’s a concept that is not widely used in primary care practice.”

—KATIE COLEMAN, M.S.P.H., DIRECTOR, MACCOLL CENTER FOR HEALTH CARE INNOVATION

Church, who has been working with the American Academy of Family Physicians and other stakeholders to improve reimbursement for care coordination efforts at the primary care level, disagrees that physicians should take on a secondary role in the care coordination process. He acknowledges, however, the challenges within the system that do not allow them to do this easily. The current coding and billing system in the United States has provided incentive for fragmented care, he says, adding that many primary care physicians already wear the hat of care coordinator without being compensated for it.

“I would wholeheartedly agree that coordinating referrals is something for the team to manage rather than the physician. It is also not uncommon for people to confuse case management with care management,” Church says. “Case management may be focused on one task, but care management explicitly addresses a comprehensive plan of care, something that family physicians are uniquely qualified for, and in many cases, (they are) the only providers willing to embrace this responsibility.”

Patients with intentional care coordination are less likely to end up in the emergency department or hospitalized, Church says, and a good primary care team is essential to helping patients avoid the hospital and achieve more efficient care. Despite the involvement of other caregivers, many patients, especially older patients and those in rural areas, turn to the primary care physician when they need something.
"If the patient perceives there is something going on with them outside the specialist, they still call me," Church says, adding that specialists play a crucial role, but a central team leader often does not exist. Without someone patients trust to fill this role, they often begin self-referrals, and this can lead to waste.

"In a world of limited resources, how can we use these resources for more bang for our buck?" Church asks.

Two big pieces of this are addressing care management codes and providing physicians with the reimbursement they need to devote time to care coordination. Church has been at the forefront of helping to improve coding for these activities. Coding for chronic care management (CCM) used to be limited to just 20 minutes, with complex care allowing for 60 or 90 minutes. Additional codes now allow for add-ons for more time, Church says, and regulators have abandoned a previous requirement that care plans had to change anytime the complex CCM codes were used. Compensating for time spent, and providing physicians with training on how to make a good, comprehensive plan of care, will benefit the process and the patients.

"We're not just your doctor at these visits. We want to encounter you throughout the year, and we want to be your doctor and team all the time," Church says. "We don't want you to wait until you need something. Both the patient and the system win when our care is proactive and intentional."

Better coding can help move this forward and allow physicians to devote the time they need to achieve better outcomes for their patients and the health system as a whole.

"It can be beneficial for patients everywhere to have primary care physicians right in the middle of that. . . . the primary care physician knows what is going on, and care can be less fragmented when the primary care physician plays an overview role."

— SAMUEL "LE" CHURCH, M.D., M.P.H., FAMILY PHYSICIAN, GAINESVILLE
Mastering care coordination

Being able to set a plan and monitor and support its progress in every respect is crucial for patients with chronic disease, and the primary care physician is uniquely positioned to do that, Church says.

“I think this is empowering for patients,” Church says. “It taps into the unique skill set of the primary care physician and improves efficiency and cost within the system without decreasing care quality. It also hits the fourth aim of the Quadruple Aim. The whole team is happier when we can be proactive in our care and improve outcomes.”

THE CASE FOR A PARADIGM SHIFT

Katie Coleman, M.S.P.H., director of the MacColl Center for Health Care Innovation and director of the Learning Health System Program at Kaiser Permanente Washington in Seattle, has focused her research on best practices for care coordination and says a lot of ambiguity exists in this area of health care. What isn’t up for debate, she says, is that the role of the primary care team is central in clinical care management.

“Repeatedly in the literature about the benefits of clinical care management, a healing relationship with the primary care physician is shown to be more cost-effective and satisfactory than other programs,” Coleman says.

The difficulty is that care coordination is a shared activity among the primary care physicians, community services and other clinicians, and navigating reimbursement is a challenge. While Coleman says the central role primary care physicians play in the care coordination process is important, she also agrees with Rath to some extent that they need to be participants — but not necessarily leaders — in the process.

“Good care coordination can’t be the responsibility of a given doctor. It’s the responsibility of a care team,” Coleman says. “That’s a concept that is not widely used in primary care practice.”

The biggest step involves the physician recognizing the need for care coordination and placing trust in the process, Coleman says. “The key is really about primary care practitioners deciding they want to improve care coordination, accepting that accountability and moving forward from there,” she explains, adding that physicians would need more than 24 hours a day to provide evidence-based care for a traditional panel of patients. “This is an impossible task if you’re asking the provider to do it themselves. It is entirely dependent on having a functioning team.”

A good team can help a patient stick to a plan developed by the primary care physician to avoid unnecessary visits, hospital stays and complications. This team can also save that patient stress and the health care system money by making sure the entire care team is involved in the patient’s journey, avoiding duplicate assessments, labs and tests, Coleman says.

“The health care system is overly complex and hierarchal when people are sick,” Coleman says, adding that duplicated, unnecessary care is a big issue facing health care and one that stems from poor care coordination.

“This is really behind a lot of the value-based payment conversations that are happening.”

Practices need to change the way they view care coordination and building teams, Coleman further explains. New billing codes to reimburse for care coordination help, but health care has a long way to go before good care coordination becomes a standard in practice.

Brian Austin, who co-founded Kaiser’s MacColl Center in 1992 and is currently its associate director, shared several resources the center has developed to help the care coordination process. These include an implementation guide and the Improving Primary Care website, which offers three modules addressing self-management, referral management and care management. These resources can help a team assess its strengths and weaknesses and create an improvement plan.

“We’ve got to put an emphasis on the primary care team, not just the doctor,” Austin says.

To move forward in this, Coleman says, primary care practices have to truly be on board with integrating care coordination and becoming a care team. For this to happen, payments have to be in their favor, and referral tracking systems need to be in place.

“We need to organize teams to manage patients at every level. It’s really thinking of the whole team as owning the care of their panel of patients,” Coleman says, adding that this means that different clinical teams have systems set up to communicate about patients and share assessment data.

“It requires a combination of payment reform and practice changes, but this is a critical issue, and I think we can get there,” Coleman concludes.
Special Report

THE 91ST PHYSICIAN REPORT

WHAT'S INSIDE

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How medical practices are faring in 2020

by KEITH A. REYNOLDS Associate Editor

The majority of physicians have seen their practice’s financial state improve or stay the same in 2019, according to the results of the 91st Annual Medical Economics® Physician Report.

In all, 23% of respondents say their practice did better financially in 2019 compared with a year prior. A further 55% say their practice is doing about the same as the year before. These figures saw a modest rise from 2018. Only 22% of respondents say their practice is doing worse than the prior year. The respondents chalk their improved performance to seeing more patients (52%), pay-for-performance incentives (29%) and changes in their practice models (26%).

Those who say their practices are worse off than a year ago cite as reasons more time spent on uncompensated tasks (67%), lower reimbursements from commercial payers (66%) and higher overhead (60%).

Compared with five years ago, 34% of respondents say they are doing better financially, and 38% say they are doing about the same.

This year’s survey garnered 1,055 responses across 17 specialties. A majority of respondents (29%) practice family medicine, with internal medicine (20%) coming in a close second.

The survey was conducted by HRA® (Healthcare Research & Analytics) via email in February 2020, before the COVID-19 pandemic began to affect the financial state of practices. Below are other highlights from this year’s report.

**SALARY**

The estimated 2019 total income for the typical physician respondent was $273,000. For those with an ownership stake in the practice, that number jumped to $289,000, while those without an ownership stake averaged about $258,000.

Within these figures, the gender pay gap is still prevalent, with male physicians making an average of $300,000 and female physicians earning an average of $226,000. Although these sums are about $6,000 lower than in 2018, the disparity remains the same at $74,000.

Incomes also vary depending on specialty. The top specialty is cardiology, with an average income of $381,000, followed by urology, with an average income of $358,000. Internal medicine physicians bring in an average of $243,000, and family medicine practitioners earn $241,000 on average.

Physicians’ pay also seems to be tied to geographic region. Physicians in the Midwest are the only ones who saw an increase in income ($2,000) between 2018 and 2019, while the Northeastern, Southern and Western parts of the country saw decreases in income.

Of the respondents, 63% say they see a minimum of 51 patients in their office in a typical workweek, while 18% see a minimum of 26 patients in the hospital.

**CHALLENGES**

The biggest challenges facing primary care practices are the continued burden of paperwork and quality metrics (74%), third-party interference (62%) and inadequate reimbursements (61%).

Respondents also cite as a challenge the average medical school debt of $161,000, and 35% cite the need for the United States to adopt a public option to supplement the Affordable Care Act.

The state of the medical profession seems strong, with 55% of respondents saying that if they could go back in time, they would choose the same medical specialty and 25% saying they would go into a different specialty. Only 15% say they would choose a different profession altogether. Additionally, 42% of responding physicians say they would recommend the medical field to their children or a friend’s child, while 32% say they would advise against that career choice.

**MALPRACTICE RATES**

For malpractice insurance, the 2019 average cost was $17,900, while 31% of respondents say they don’t know what their premiums are. Regarding changes, 59% say their premiums stayed the same from 2018 to 2019. A further 23% say it increased, while only 5% saw a decrease in premiums. Thirteen percent of respondents say they don’t know whether there was a difference in premiums between the two years.

The median annual malpractice premium for respondents who describe themselves as practicing family medicine is $8,100; for internal medicine, $8,500; and for cardiology, $18,000. Male physicians saw a higher median annual malpractice premium, at $10,300, than female physicians, who saw a median premium of $9,300.

To help boost their business, a vast majority (82%) of physician respondents say their practice offers a minimum of 26 patients in a typical workweek, while 18% see a minimum of 51 patients in their office in a typical workweek, while 18% see a minimum of 26 patients in the hospital.

**Continued on page 14**
or imaging services (25%) and nutritional or weight loss counseling (24%). About half of the respondents estimate that between 1% and 10% of their 2019 revenue was generated by these ancillary services.

PRIOR AUTHORIZATIONS
For prior authorizations, a perennial annoyance, physicians spend an average of 11 hours a week, while office staff spend 14 hours a week on average on them. Thirty-five percent of respondents cite this time spent as the biggest frustration with prior authorizations. Coming in a close second (34%) is the feeling that insurers were telling physicians how to do their jobs.

STAFFING
The average physician respondent says they employ 4.4 medical assistants, 3.4 front desk workers, 2.9 registered nurses, 2.7 nurse practitioners or physician aides, 2.5 billers or coders, 2.5 schedulers, 2.3 office managers or administrators of social services or care coordinators, 1.6 information technology (IT) staff members and one pharmacist.

The majority of respondent practices (63%) currently have no IT staff, but that is likely to change in the near future as practices and the Centers for Medicare & Medicaid Services are forced to move toward telehealth solutions because of the ongoing COVID-19 pandemic.

ABOUT THE SURVEY
The 91st Annual Physician Report was conducted by HRA® (Healthcare Research & Analytics), a full-service health care market research agency and a brand of MJH Life Sciences™. Data were collected from physicians who responded to email invitations to take the survey during February 2020.
Financial state of my medical practice, five years ago:

Better than 5 years ago: 2018 - 31%, 2019 - 34%
About the same: 2018 - 34%, 2019 - 35%
Worse than 5 years ago: 2018 - 34%, 2019 - 29%

Why my finances improved or worsened in 2019:

**Top reasons finances improved**
1. More patients seen
2. Pay-for-performance incentives
3. Change in practice model
4. Renegotiation of payer contracts
5. Addition of ancillary services

**Top reasons finances worsened**
1. More time spent on uncompensated tasks
2. Lower reimbursement from commercial payers
3. Higher overhead
4. Difficulty collecting from patients
5. Greater technology costs

The top nine issues faced by primary care physicians in 2019:

*Arrow indicates change from previous year.

1. Burden of paperwork/quality metrics
2. Third-party interference (e.g., prior authorizations)
3. Inadequate reimbursement
4. Lower reimbursement for primary care compared with specialty care
5. EHRs not working as well as they need to
6. Recruitment of young physicians
7. Malpractice/need for tort reform
8. Growth and competition of convenient care/retail clinics
9. Patients getting health information online
### AVERAGE INCOME BY PRIMARY CARE SPECIALTY

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine</td>
<td>$212,000</td>
<td>$230,000</td>
<td>$262,000</td>
<td>$243,000</td>
<td>-$19,000</td>
</tr>
<tr>
<td>Family medicine</td>
<td>$187,000</td>
<td>$205,000</td>
<td>$242,000</td>
<td>$241,000</td>
<td>-$1,000</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$187,000</td>
<td>$205,000</td>
<td>$233,000</td>
<td>$231,000</td>
<td>-$2,000</td>
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<tr>
<td>Cardiology</td>
<td>$412,000</td>
<td>$415,000</td>
<td>$405,000</td>
<td>$381,000</td>
<td>-$24,000</td>
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<tr>
<td>OB-GYN</td>
<td>$237,000</td>
<td>$271,000</td>
<td>$288,000</td>
<td>$298,000</td>
<td>+$10,000</td>
</tr>
</tbody>
</table>

Average pretax income comparison for both employed physicians and practice owners.

### AVERAGE INCOME BY GENDER

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Difference</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>$257,000</td>
<td>$190,000</td>
<td>$67,000</td>
</tr>
<tr>
<td>2014</td>
<td>$266,000</td>
<td>$191,000</td>
<td>$75,000</td>
</tr>
<tr>
<td>2016</td>
<td>$270,000</td>
<td>$204,000</td>
<td>$66,000</td>
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<tr>
<td>2017</td>
<td>$268,000</td>
<td>$207,000</td>
<td>$61,000</td>
</tr>
<tr>
<td>2018</td>
<td>$306,000</td>
<td>$232,000</td>
<td>$74,000</td>
</tr>
<tr>
<td>2019</td>
<td>$300,000</td>
<td>$226,000</td>
<td>$74,000</td>
</tr>
</tbody>
</table>

$273,000  $74,000

2019 physician average pretax income  Difference in pretax income between male and female physicians in 2019

### AVERAGE INCOME BY COMMUNITY

<table>
<thead>
<tr>
<th>Year</th>
<th>Urban</th>
<th>Suburban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>$247,000</td>
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<td>$223,000</td>
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<tr>
<td>2014</td>
<td>$236,000</td>
<td>$248,000</td>
<td>$232,000</td>
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<td>2016</td>
<td>$254,000</td>
<td>$257,000</td>
<td>$230,000</td>
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<tr>
<td>2017</td>
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<td>$249,000</td>
<td>$230,000</td>
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<td>2018</td>
<td>$283,000</td>
<td>$285,000</td>
<td>$274,000</td>
</tr>
<tr>
<td>2019</td>
<td>$260,000</td>
<td>$280,000</td>
<td>$281,000</td>
</tr>
</tbody>
</table>
Average income by practice ownership:

$31,000

The gap in income between practice owner and non-owner physicians.
**Average number of patient office visits per week:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Family</th>
<th>Internal</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>89</td>
<td>85</td>
</tr>
<tr>
<td>2014</td>
<td>90</td>
<td>87</td>
</tr>
<tr>
<td>2016</td>
<td>85</td>
<td>76</td>
</tr>
<tr>
<td>2017</td>
<td>83</td>
<td>73</td>
</tr>
<tr>
<td>2018</td>
<td>85</td>
<td>82</td>
</tr>
<tr>
<td>2019</td>
<td>76</td>
<td>74</td>
</tr>
</tbody>
</table>

Average number of patient office visits for all physicians: 74

**Average number of patient office visits per week, per practice ownership:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Private</th>
<th>Hospital-owned practice</th>
<th>Nonprofit</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>89</td>
<td>80</td>
<td>60</td>
<td>52</td>
</tr>
<tr>
<td>2018</td>
<td>91</td>
<td>90</td>
<td>75</td>
<td>78</td>
</tr>
<tr>
<td>2019</td>
<td>77</td>
<td>76</td>
<td>66</td>
<td>65</td>
</tr>
</tbody>
</table>

Where physicians saw patients in 2019 (average number of patients per week):

- **74%** Office
- **35%** Hospital
- **25%** Senior residences/nursing homes
- **23%** Telehealth
- **17%** Patient homes

Average number of patients per week physicians saw using telehealth: 23
Average number of hours worked per week:

<table>
<thead>
<tr>
<th>Year</th>
<th>Family</th>
<th>Internal</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>51</td>
<td>52</td>
</tr>
<tr>
<td>2014</td>
<td>51</td>
<td>53</td>
</tr>
<tr>
<td>2016</td>
<td>52</td>
<td>54</td>
</tr>
<tr>
<td>2017</td>
<td>52</td>
<td>54</td>
</tr>
<tr>
<td>2018</td>
<td>52</td>
<td>53</td>
</tr>
<tr>
<td>2019</td>
<td>48</td>
<td>51</td>
</tr>
</tbody>
</table>

Malpractice Rates

Change in malpractice premiums for 2019 compared with 2018:

- 23% Increased
- 59% Stayed the same
- 5% Decreased
- 13% Don’t know

Change in malpractice premiums compared with five years ago:

- 42% Increased
- 34% Stayed the same
- 11% Decreased
- 13% Don’t know

Median annual malpractice premiums for primary care physicians, 2019:

- Cardiology: $18,000
- Family medicine: $8,100
- Internal medicine: $8,500

Median annual premiums by gender, 2019:

- Women: $9,300
- Men: $10,300
### Median annual premiums by geographic region, 2019:

<table>
<thead>
<tr>
<th>Region</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>$11,900</td>
</tr>
<tr>
<td>South</td>
<td>$10,750</td>
</tr>
<tr>
<td>Midwest</td>
<td>$9,000</td>
</tr>
<tr>
<td>West</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

### Median annual malpractice premiums by practice ownership, 2019:

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital inpatient</td>
<td>$12,600</td>
</tr>
<tr>
<td>Hospital-owned practice</td>
<td>$11,700</td>
</tr>
<tr>
<td>Private practice</td>
<td>$9,800</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>$6,000</td>
</tr>
<tr>
<td>Government</td>
<td>$3,700</td>
</tr>
</tbody>
</table>

### Median annual premiums by years in practice, 2019:

<table>
<thead>
<tr>
<th>Years in Practice</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10 years</td>
<td>$8,200</td>
</tr>
<tr>
<td>11-20 years</td>
<td>$11,000</td>
</tr>
<tr>
<td>21-30 years</td>
<td>$10,700</td>
</tr>
<tr>
<td>31-40 years</td>
<td>$9,700</td>
</tr>
<tr>
<td>&gt;40 years</td>
<td>$6,900</td>
</tr>
</tbody>
</table>

### ANCILLARY SERVICES

#### Most popular ancillary services in internal medicine/family medicine, 2019:

1. Electrocardiogram: 52%
2. Lab services: 48%
3. Spirometry: 28%
4. Radiology/imaging services: 25%
5. Nutritional counseling/weight loss: 24%
6. Holter monitoring: 16%
7. Implantable contraceptives: 15%
8. Pain management: 14%
9. Stress tests: 13%
10. Addiction medicine: 12%

#### Percentage of revenue for primary care from ancillary services (average), 2019:

- Cardiology: 23%
- OB-GYN: 13%
- Internal medicine: 12%
- Family medicine: 12%
- Pediatrics: 11%
SECONDARY INCOME

Did you earn income from an employment source outside your practice?

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>30%</td>
<td>69%</td>
<td>1%</td>
</tr>
<tr>
<td>2016</td>
<td>33%</td>
<td>66%</td>
<td>1%</td>
</tr>
<tr>
<td>2017</td>
<td>30%</td>
<td>69%</td>
<td>1%</td>
</tr>
<tr>
<td>2018</td>
<td>32%</td>
<td>68%</td>
<td>0%</td>
</tr>
<tr>
<td>2019</td>
<td>30%</td>
<td>70%</td>
<td>0%</td>
</tr>
</tbody>
</table>

27% of physicians who earned secondary income in 2019 did so by providing consulting services.

Top 10 sources of secondary income, 2019:

1. Consulting: 27%
2. Teaching: 14%
3. Clinic work: 13%
4. Nonmedical work: 13%
5. Medical administrator: 12%
6. Clinical trials/research: 9%
7. Hospice: 7%
8. Locum tenens assignments: 7%
9. Nursing home: 7%
10. Telemedicine: 3%

Amount of secondary income (average), 2019:

- Internal medicine: $42,000
- OB-GYN: $41,300
- Family medicine: $40,400
- Cardiology: $37,600
- Pediatrics: $36,000

PRIOR AUTHORIZATIONS

Time spent weekly on prior authorizations, 2019:

- Physicians: 2% >20, 15% 11-15, 31% <10, 32% 0
- Practice staff: 2% >20, 10% 11-15, 31% <10, 23% 0

Average number of hours per week for physicians: 11
Average number of hours per week for staff: 14
**Special Report**

91st Annual Physician Report

**Biggest frustration with prior authorizations?**

- 35% Time spent on authorizations
- 34% Feeling as though a payer is telling me how to do my job/what’s best for my patients
- 10% Reasons for denial
- 7% Lack of clarity on what requires a prior authorization
- 6% No frustration with prior authorizations
- 5% Managing the number of outstanding requests
- 2% Other

**MEDICAL LIFESTYLE**

If you could go back in time and choose your career again, you would choose?

- 55% The same specialty
- 25% A different specialty
- 15% A different career altogether
- 5% Prefer not to answer

Would you recommend that your child or a friend’s child pursue a career in medicine?

- 42% Yes
- 32% No
- 25% Not sure
- 1% Prefer not to answer
WHO TOOK THE SURVEY

Physician's age:
- <35: 1%
- 35-44: 11%
- 45-54: 30%
- 55-64: 35%
- >65: 23%

Physician's gender:
- Female: 36%
- Male: 64%

Do you have an ownership interest in your practice?
- Yes: 49%
- No: 51%

Practice region:
- Midwest: 35%
- Northeast: 24%
- South: 22%
- West: 19%

Practice specialty:

Practice type:
- Private practice: 54%
- Hospital-owned practice: 19%
- Hospital: 10%
- Other: 7%

Practice size:
- Solo practice: 30%
- 2-10 physicians: 36%
- 11-25 physicians: 13%
- More than 26 physicians: 21%
Health care reform: How it would affect physicians

What doctors need to know about transforming the health care insurance system — and what it would mean to their practices

by TODD SHRYOCK  Managing Editor

Single payer. Medicare for all. Public option. These terms are bandied about by presidential candidates and health care experts, but what do they really mean?

At face value, they sound good for patients, who would no longer have to worry about paying for the care they need. Increased use of primary care services could help lower overall health care costs as chronic patients get regular checkups and patients no longer delay care due to cost concerns.

For these and other reasons, the American College of Physicians (ACP) released its own guidance endorsing many of the concepts of a single-payer system — one where private health insurance would be replaced by the government — or a system where people could opt in to Medicare, effectively making it a competitor for private insurance, which would then be heavily regulated.

Much has been discussed about the benefits for patients, but what would a single-payer system mean for doctors? How would it affect their reimbursements, their administrative burden and their level of burnout? Experts say dissecting the specifics can be challenging because the definition of each concept varies depending on who’s talking, even if they use the same terminology. But if enacted, the broad changes would be significant, including some that may surprise many physicians.

REIMBURSEMENT CHANGES

One of the advantages of a single-payer system for physicians in private practice would be simplified billing.

“Each payer often uses its own standards for submitting a claim, and all have different payment policies,” says Anders Gilberg, MGA, senior vice president of government affairs for the Medical Group Management Association. This billing complexity often requires the use of a clearinghouse to adjudicate all the various policies, something that would not be needed if there were only one payer with one set of rules to follow.

“The administrative burden would be lower compared to having all these different systems, but how that plays out depends on what the final plan would look like,” says Jodi Liu, Ph.D., a health care
policy researcher for the Rand Corp. “All payments would be processed through one fee schedule. There is quite a lot of administrative staff needed to deal with billing and processing, which may no longer be needed. For practices seeing patients with private insurance now, they are likely to see decreased payments, so some of this may be offset by savings in administration.”

The possibility of lower reimbursements through either reduced government payments or the loss of typically higher-paying commercial insurers is something physicians need to consider, says Gary Price, M.D., president of The Physicians Foundation.

“I suspect that because of the program’s huge costs, doctors will be under more pressure to see more patients in less time,” Price says, adding that he doubts any administrative cost savings will be enough to make up for falling reimbursements.

Robert McLean, M.D., FACP, president of the American College of Physicians (ACP), says that switching to a single-payer system would also require rethinking the current Medicare rates to make it work. “People should not be afraid that we are going to switch over and that everyone just gets stuck with the current Medicare rates — and told to suck it up,” says McLean. Physicians should have input on reexamining rates, and with the reduction of administration across the entire system — plus the elimination of insurance company expenses — there should be more money to pay physicians.

“Patients are paying more, but the insurance companies are making a lot of money off the backs of patients, who have higher copays and deductibles,” says McLean. “Any system needs to be fair and reasonable and avoid all the cost shifting.”

In the current system, doctors in private practice can opt out of Medicare and, depending on their financial situation, also choose not to do business with any commercial payers that are overly burdensome. “What remains to be seen is whether doctors would have the opportunity to opt out of a single-payer system and would they have any free-market negotiating power,” says Gilberg. “There is speculation that if physicians were allowed to opt out, you would create a dual system where the people with money would have better access to specialists, subspecialists and certain experts in various fields, while the others would be covered by the single-payer system. This brings up questions about access to care and timeliness.”

A single-payer system with government-controlled reimbursement rates may also affect how doctors are trained and how that training is financed. “If you go to medical school today, you’re likely to come out with excess of $200,000 in debt,” says Gilberg. “If we went to a single-payer system and reduced the salaries of physicians, we would also have to reform the entire way physicians are trained in this country and subsidize that. If they’re trained in the system, are they required to stay in the system?”

Price says the effect of a single-payer system on specialty choice by medical students is also unknown, and those specialties requiring a longer commitment will need to collect increased reimbursement somehow. But McLean says the reimbursement for primary care also needs to increase because there is already a shortage of primary care physicians — and more will be needed to help people stay out of the hospital and to provide more cost-effective care. “Does that necessarily mean that the specialist needs to get paid less? The answer is no,” says McLean.

How do you think the U.S. should reform its health insurance system?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need a public option to supplement the Affordable Care Act</td>
<td>36%</td>
</tr>
<tr>
<td>Should repeal the Affordable Care Act</td>
<td>20%</td>
</tr>
<tr>
<td>Should keep the private insurance system but increase regulation</td>
<td>19%</td>
</tr>
<tr>
<td>Need a single-payer health system (i.e., Medicare for All)</td>
<td>18%</td>
</tr>
<tr>
<td>Need a national health system where doctors work for the government</td>
<td>5%</td>
</tr>
<tr>
<td>System is fine as it is</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Medical Economics* 2020 Physician Report
Health care reform

“...The burden is unnecessary regulations and silly quality measures at the patient-care level, and it adds to burnout. This is a huge problem area already, and I think single-payer would make it worse.”

—GARY PRICE, MD, PRESIDENT, THE PHYSICIANS FOUNDATION

With insurance companies taking 20% to 30% of every health care dollar, he says there is plenty of money that can be allotted to decrease costs for patients and appropriately pay doctors.

PATIENT CARE & QUALITY
How doctors care for patients may also change under a single-payer system, experts say. “Would they still be able to determine what care they can provide the same way they do now?” asks Liu. “The two proposals in Congress now provide comprehensive care for the services that you would expect, but there would need to be some way to figure out what care patients could receive. As new therapies and treatments come out, how would they be covered? ... There are a lot of cost implications to the system.”

Also unknown is what would happen to prior authorizations. A single-payer system would result in one set of patient treatment guidelines, which might reduce doctors’ administrative burden, but authorizations from Medicare may still be required for some nonstandard treatments or drugs.

Gilberg says that for any system to be effective, more money would have to be invested in preventive care, but the system would also likely include quality metrics to measure doctor effectiveness, whether through something similar to the current Merit-Based Incentive Payment System (MIPS) program or something new.

“Most physicians’ gut feelings are that quality measures would get exponentially worse in a single-payer system,” says Price. “The burden is unnecessary regulations and silly quality measures at the patient-care level, and it adds to burnout. This is a huge problem area already, and I think single-payer would make it worse.”

The ACP plan calls for a revamped system of quality measures developed with more input from physicians. “Yes, quality metrics need to be there, but we need to [help] drive that because they are tremendously tricky,” says McLean.

But the ACP also recommends a system that would more comprehensively address how social determinants affect a patient’s overall health. “Whether it’s people getting food or shelter or whatever it is, we need to recognize that these play a significant role in our population’s health, which has a significant role in our individual patient’s health,” says McLean. For example, a system that addresses the source of bad air in public housing is a lot cheaper than paying for repeated emergency department (ED) visits by asthmatic patients, he says. This also benefits doctors.

FEASIBILITY
Moving the country from its current way of paying for health care to a single-payer system would be complicated and could create some additional risks to patients. “You would have to be really careful because moving people slowly to a single-payer system would remove some of the financial viability of the insurance market,” says Gilberg. Some companies might go out of business or drastically narrow their networks, he adds.

Liu says that any transition is likely to take up to two years, and politicians would have to carefully craft plans to cover any gaps for patients who lose their commercial insurance because of disruptions to the insurance market.

The changes that came about from the Affordable Care Act (ACA) offer some insight into the types of challenges the government may face in any switch, ranging from buggy websites to a skeptical public. “I would hope the government planners would be wise enough to implement it in a way that those things wouldn’t happen, but I would be shocked if there weren’t a lot of headaches,” says Price. “Personally, I think the speed it’s implemented will be determined by the legislators’ willingness to finance it. The financing piece is really the limiting factor.”

With current split control of the U.S. Senate and House of Representatives, the likelihood remains low that any major change will take place. And even if Democrats could gain control of the Senate, any changes they make could be undone by the next change of power, Gilberg says.

McLean says any change won’t be easy, but the time is ripe.

“I think people were enticed by the promise of a better health care system with the ACA, and having that partially take place, then be subsequently stripped away has a lot of people really angry and frustrated,” he says. “I think the level of dissatisfaction among the people of this country is higher than people might realize. But that needs to be reflected up to the legislators for things to be done, and that’s a tough one.”
or primary care physicians — already saddled with student debt obligations, volume-based performance demands, declining reimbursements, increasing administrative challenges, and overall burnout — the spread of COVID-19 has been a pressure test. It has exposed weaknesses in the financial, clinical and operational aspects of primary care, and left thousands of doctors scrambling to save their practices. More than 70% of practices reported a decrease of 50% or more in patient volumes; fewer than half feel they have sufficient patient volume or cash-on-hand to remain open.

Independent primary care providers, in particular, find themselves at a critical point: Do I join a health system or large practice, or can I sustain my business as an independent practice?

For physicians committed to their independence, the good news is that the same factors that made concierge practices strong enough to survive dramatic health care reform have enabled them to withstand the current COVID-19 crisis.

FINANCIAL BENEFITS
Concierge practices are better equipped to weather the current environment with more reliable cash flows from annual membership revenues, between $1,800 and $2,000 on average, that provide cushion against a sudden cash crunch. Additionally, concierge patients are reluctant to leave their physician, which creates a more consistent patient base — Specialdocs’ average patient renewal rate is 96%.

CLINICAL BENEFITS
The size of traditional primary care patient panels has presented clinical difficulties in the current crisis. On average, an Internal Medicine or Family Medicine physician cares for over 1,600 patients. With panels this large, doctors have limited time to manage care, communication and outreach. Adding in the number of COVID-19 questions and cases has proven overwhelming, making efforts to educate patients on procedures for office or telehealth visits challenging.

In contrast, a concierge physician typically has between 250 and 600 patients, making outreach, communication and care much more manageable. During the COVID-19 emergency, Specialdocs concierge physicians promptly and effectively utilized digital communication and telehealth to serve patients, especially the elderly and those with chronic conditions, and both patients and physicians report high satisfaction as a result.

OPERATIONAL BENEFITS
Operationally, traditional primary care practices are not well positioned to weather crises like COVID-19. Recent surveys show that 48% of independent physician practices have temporarily furloughed staff, and 22% have permanently laid off staff. Even when the current emergency abates, traditional practice models designed to treat 1,600 patients may not fit the new environment.

Concierge practices are lean by design, typically consisting of one physician who manages up to 600 patients with two or three staff members. Amidst the COVID-19 crisis, no Specialdocs physician has implemented staff reductions.

The impact of the COVID-19 crisis is still unfolding. Systems that worked previously can no longer be depended on. Concierge medicine is an important piece of reshaping the primary care system by offering more flexibility and stability, personalized care and greater satisfaction for physicians and their patients.

Dave Farr is vice president of business development at Specialdocs, a concierge practice transition and management firm.
Manage HIPAA risks in your practice

What physicians need to do about HIPAA, telehealth and managing billing staff working remotely

by AINE CRYTS Contributing author

Video chat tools such as FaceTime, Skype and Zoom are now available to physician practices that want to treat patients on a remote basis, according to March 17, 2020, guidance from the Department of Health and Human Service’s Office for Civil Rights (OCR), which enforces the Health Insurance Portability and Accountability Act (HIPAA).

Michele P. Madison, J.D., a health care attorney at Morris, Manning & Martin in Atlanta, points out that OCR won’t enforce penalties for physician practices that use “non-public-facing video and audio technology that’s not secure, and they won’t require business associate agreements.” Still, she advises that practices take the following steps:

- Validate that the physician or other clinician is licensed to provide care by telemedicine in the state where they’re providing the service.
- Secure verbal or written confirmation that patients understand that the platform used to receive telehealth-based care isn’t secure.
- Communicate to physicians and clinicians that they must fully and completely document the interaction with patients, including their clinical findings, medical decision-making and other necessary variables to support the Current Procedural Terminology code used by the billing department.

According to the OCR guidance, platforms such as Facebook Live, TikTok and Twitch are examples of public-facing video communications platforms, and providers shouldn’t use them when providing care to patients.

BILLING FOR TELEHEALTH VISITS

Elizabeth P. Litten, J.D., a health care attorney and chief privacy and HIPAA compliance officer at Fox Rothschild in Princeton, N.J., points out that practices need to ensure they’ll be reimbursed for the care provided using telehealth. This is determined on a state-by-state basis, she adds. Kelli Carpenter Fleming, J.D., an attorney at Burr & Forman in Birmingham, Ala., advises practices to check with health insurers to make sure they’ll be paid for the patient visit.

The Centers for Medicare & Medicaid Services (CMS) has said that Medicare will reimburse health care providers for treating patients using telehealth for COVID-19.
and other medically reasonable purposes from offices, hospitals and residences such as homes, nursing homes and assisted living facilities. The federal agency noted that Medicare Advantage plans may offer additional telehealth services beyond what was included in its approved 2020 benefits.

States “have broad flexibility to cover telehealth through Medicaid, including the methods of communication (such as telephone, video technology commonly available on smartphones and other devices) to use,” according to April 2 guidance from CMS. In addition, states aren’t required to seek federal approval “to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services,” CMS notes.

Fleming highlights that OCR’s March 20 guidance says that a telehealth-based visit doesn’t have to be for a COVID-19-related condition. That means, for example, that a physician can use telehealth to consult with a patient about an earache, she says.

DISCLOSING PHI
OCR’s March 24 guidance provided insight into ways that health care providers can disclose protected health information (PHI) about a person who has been infected by or exposed to the COVID-19 virus. Health care organizations can disclose PHI, including the name and other identifying information about the person, under the following four circumstances:

- When needed to provide treatment
- When required by law
- When first responders may be at risk for an infection
- When disclosure is necessary to prevent or lessen a serious and imminent threat

Fleming points out that this allows a call center employee or an emergency medical technician to communicate to a physician or other clinician that the patient has been around someone with COVID-19 or has tested positive for the disease. It also allows health care providers to adequately respond and protect themselves, she explains. But she points out that this type of communication has always been permissible between first responders and health care providers.

MANAGING BILLING STAFF
To date, 42 state governors have issued stay-at-home orders or advisories, which generally mean that only essential personnel should show up physically at their workplaces. In addition, OCR issued guidance on April 2 that it won’t impose penalties for violations of some provisions of the HIPAA Privacy Rule against health care providers and their business associates “for good faith uses and disclosures of protected health information … by business associates for public and health and health oversight activities during the COVID-19 nationwide public health emergency.”

In a statement, Roger Severino, director of OCR, said, “Granting HIPAA business associates greater freedom to cooperate and exchange information with public health and oversight agencies can help flatten the curve and potentially save lives.”

Some clinicians may be able to provide telehealth consults from their home offices, whereas administrative employees who aren’t patient facing can work remotely, with the right guidance. Alissa Smith, J.D., an attorney at Dorsey & Whitney in Des Moines, Iowa, points out that employees providing administrative and billing support can work from home. Her advice for physician practices with billing employees working from home includes the following:

- Keep billing files and other patient records away from others in the household.
- Use safeguards, such as firewalls, encryption and a private network, to prevent patient information from being hacked.

Fleming recommends that practices require remote billing staff to log in to the practice’s systems using two-factor authentication. That requires a code to be sent to the billing employee’s cellphone for an additional level of security.

Practices should discourage employees from saving any files onto the hard drives on their computers at home, says Fleming. In addition, the employee’s computer should be set up to require an additional login if the computer isn’t in use for three minutes or even less. Employees should also limit printing of any patient information, she adds.

Most payers allow providers up to a year to drop a claim, says Fleming. But waiting to send claims to health insurers will hurt the practice’s cash flow.

Physicians tell her that billing employees “are essential — they help me keep my doors open,” she adds.
As the COVID-19 pandemic increases the numbers of critically ill patients flowing into hospitals, doctors in many areas are facing an increased shortage of vital equipment and supplies. In some cases, this can present ethical dilemmas to physicians who must choose between patients and their own safety when providing care.

Medical Economics spoke with Jeremy A. Lazarus, MD, a member of the Council on Ethical & Judicial Affairs at the American Medical Association (AMA) and former AMA president, about the challenges physicians are confronting and how to handle these difficult situations.

Q: Medical Economics: During this pandemic, what kind of ethical dilemmas are physicians facing, and what dilemmas do you expect them to face as the crisis deepens?

Jeremy Lazarus: The most pressing dilemmas that have emerged to this point are ... shortages of essential resources, especially personal protective equipment (PPE) for frontline clinicians and the looming prospect of having to make extremely difficult decisions about which patients will, or won’t, have priority claim on our limited supply of ventilators. Physicians are facing very difficult choices under conditions of great uncertainty — we just don’t have good data yet.

Most of us, in the U.S. certainly, have never been in situations where what is widely seen as optimal care simply may not be feasible. We can’t practice the way [we’re] used to, and that’s very unsettling. But that’s exactly what we have to do in a pandemic when the demand suddenly becomes so much greater than our capacity.

Q: ME: How should physicians approach these decisions?
**JL:** Physicians shouldn’t be left to make these decisions individually. They need guidance — from their institutions, their states or national bodies. Having the institution make the call, in a systematic way, about who gets a ventilator and who doesn’t is far preferable from an ethics perspective than leaving that to the patient’s caregiver. Having a designated committee or institutional officer make the call based on objective guidelines helps ensure that decisions are fair and takes the burden off physicians and other clinicians who are providing care for the individual patients affected.

We know that many institutions and states have policies that they’re updating in light of what we know currently about COVID-19; others are developing them. The AMA is gathering triage guidelines from many sources with the goal of posting examples.

**Q:** ME: How can physicians deal with the mental stress of making life-or-death decisions caused by equipment shortages?

**JL:** Institutional protocols for making the life-and-death decisions that we’re going to face is one of the most effective ways to help physicians cope with the uncertainty and the psychological toll of the pandemic. But we’re also seeing virtual professional communities emerge with physicians sharing information, concerns, ideas — on Twitter for example. Not just with clinicians in their local institution or community, but across state lines and even internationally. Having the support of colleagues who are facing the same dilemmas can be enormously helpful.

This started out as ad hoc communication, but institutions and communities are beginning to create virtual activities more systematically. Things like virtual town halls can connect physicians to one another and bring the public into the conversation in ways that support everyone. The state medical society in Colorado, where I live, has been holding these virtual town halls bringing in state public health experts to update us on the situation in Colorado and responding to questions from practicing and retired physicians.

**Q:** ME: With a shortage of PPE, what ethical dilemmas do physicians face when it comes to caring for a patient who may be infected with the COVID-19 virus but lacking the proper equipment to safely treat the patient?

**JL:** One of the commitments physicians make [when] entering the profession is to accept greater-than-usual personal risk in times of urgent need, such as [a pandemic]. In the best of all possible worlds, of course we’d provide them with top-of-the-line personal protective equipment because we also need to protect the physician workforce to meet ongoing chronic health needs. When there’s a shortage of PPE, physicians may have to be willing to accept suboptimal, but safe, protection — at least until supplies can be replenished.

Decisions to allocate PPE are similar to those to allocate ventilators or other supplies for patient care. And like other allocation decisions, the institution should have a protocol for how to make them. [The] personnel [who] have the most urgent need for PPE because they are exposed to the greatest risk caring for seriously ill COVID-19 patients have a strong claim to available protection. There may be other options for protecting physicians who are personally at high risk because of an underlying medical condition — if they can be assigned to provide care to non-COVID-19 patients, for example.

The institution should also explore options for increasing the supply of PPE or determining whether PPE can be adequately sterilized and safely reused until supplies of new equipment are available. Or find other creative ways to meet the need.

**Q:** ME: Many physicians have young children or elderly parents at home. Is it ethical “Balancing the professional commitment to provide urgently needed care [during] a pandemic with responsibility to one’s family is tough.”

Decisions to allocate PPE are similar to those to allocate ventilators or other supplies for patient care. And like other allocation decisions, the institution should have a protocol for how to make them. [The] personnel [who] have the most urgent need for PPE because they are exposed to the greatest risk caring for seriously ill COVID-19 patients have a strong claim to available protection. There may be other options for protecting physicians who are personally at high risk because of an underlying medical condition — if they can be assigned to provide care to non-COVID-19 patients, for example.

The institution should also explore options for increasing the supply of PPE or determining whether PPE can be adequately sterilized and safely reused until supplies of new equipment are available. Or find other creative ways to meet the need.

**Q:** ME: Many physicians have young children or elderly parents at home. Is it ethical...
for them to not show up for shifts at a hospital where COVID-19 is prevalent? How should physicians keep their families safe while still meeting their ethical obligations as a doctor?

**JL:** I don’t think we know just how many physicians have family or household members who are at high risk, but we do know they’re out there. Balancing the professional commitment to provide urgently needed care [during] a pandemic with responsibility to one’s family is tough. Physicians need to think carefully about what a decision not to show up for work will mean, what burdens it will place on their patients and [on] colleagues who will have to pick up the slack. Following strict infection-control measures at home should be a first choice. The risk to the physician would have to be very compelling to justify a decision not to go to work.

But again, this isn’t a decision that an individual physician should make, or be asked to make, on their own. Health care institutions have a responsibility to provide guidance for their staff.

**Q:** **ME:** What are the ethics around not allowing end-of-life visits by family members, leaving someone to die alone?

**JL:** The prospect of patients dying alone because protecting the well-being of the community means that family members won’t be allowed to see their loved ones is appalling. ... It can help to remember that we do it to protect the living, including family members.

But again, this isn’t a decision that an individual physician should make, or be asked to make, on their own. Health care institutions have a responsibility to provide guidance for their staff.

“...The prospect of patients dying alone because protecting the well-being of the community means that family members won’t be allowed to see their loved ones is appalling. ... It can help to remember that we do it to protect the living, including family members.”

**Q:** **ME:** Are there ethical resources doctors should know about?

**JL:** The [AMA] is developing short-use cases that apply guidance from the AMA Code of Medical Ethics to issues as they are emerging in the pandemic. [These] are posted to the AMAs COVID-19 Resource Center as they become available. The full code is available online at [https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview](https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview).
8 ways to evaluate a telehealth vendor

by CHRIS MAZZOLINI, M.S. Editorial Director

Many physicians are now looking to hire a telehealth service company to expand access to care for patients during the COVID-19 pandemic.

Even though practices want to start their telehealth program quickly, do not rush due diligence. To help physicians evaluate potential vendors, the American Medical Association (AMA) recently released Telehealth Implementation Playbook, a guide with key tips and updates on telemedicine expansion. In it, they include criteria that physicians should consider when selecting a vendor.

Basic business information
What’s the company’s organizational overview?
- How long have they been around?
- What’s their funding source? Are they financially stable?
- Who are they affiliated with?
- Do they have any notable customers?

Cost and prices
How will this company impact your program’s return on investment?
- How much does the product cost?
- What’s their business model?
- What are details on reimbursement rates, risk sharing and more?
- What’s the cost, process and timeline associated with integration and any product updates?

Is it a fit?
How well do they know you?
- Do they have expertise in offering telehealth to your specialty?
- Do they have knowledge of federal and private-payer requirements?
- Do they know the laws and regulations in your state?

Technology needs
Does their tech match your needs?
- Can they integrate with your information technology landscape, particularly your electronic health record (EHR) platform?
- Can their system capture data important to both the care team and the patient?

Cybersecurity and privacy
Does the vendor have a secure system?
- Do they comply with HIPAA rules?
- Will they sign a business associate agreement with your practice?
- What is their liability structure for managing security breaches?
- Do they comply with local regulations, such as state medical board rules?

System usability
How well does their system work?
- How easy is their system for clinicians and patients to use?
- Does it provide engagement metrics?
- How well does the dashboard and workflow systems work?
- How easy is the billing system?

Vendor support services
How is their customer service?
- How much initial training do they provide?
- How much support do they provide beyond initial training?
- Patient education? Project management? Data analysis?
- What is their technical support process like?
- Do you have access to existing templates and procedure examples?

Clinical validation
Is their system credible clinically?
- Do they have documentation that supports improving clinical outcomes?
- Is there any published peer-reviewed research of their system?
“I’m going to prescribe for you to stay away from the news on TV and all social media!”

How to find the right career — and negotiate what you want from it

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- Reimburses using 6 CPT codes, National Average = $750 - $1000 per test
- Each test is processed into a fully-finished, clinically actionable report
- Easy to understand biomarkers facilitate more informed medical interventions, such as biofeedback

ANS TESTING
- Can be combined with SUDOMOTOR
- Takes less than 10 minutes to perform, software provides verbal cues
- Tests for autonomic balance, vascular health, physical/mental stress, peripheral nerve health and other critical hidden risk factors
- Reimburses $170/test using 3 CPT codes
- Provides a 1 page summary up to a full 34 page comprehensive report

SUDOMOTOR TESTING
- Can be combined with ANS
- Takes 3 minutes to analyze a patients’ hands and feet
- Provides a 1 page summary report
- Assesses peripheral nerve health (c-fiber function) and asymmetry between each hand and foot
- Reimburses $130/test (national average)

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*Dr. Walter is UroLift System faculty and a paid consultant for NeoTract | Teleflex
1. AUA Guidelines 2003, 2010
2. Speakman et al. 2014 BJU International
3. Roehrborn J Urol 2013 LIFT Study
4. Shore, Can J Urol 2014 Local Study
5. AUA BPH Guidelines 2003

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Dear Reader,

The one constant in health care is change. From technology advancements and new treatment options to economic challenges and, as the current landscape has proven, unpredictable outbreaks.

To be more responsive to the evolving health care landscape, Medical Economics® is strengthening our digital footprint while refocusing our print publication on more enduring content. As a result of the shift, we will enhance our digital platform with even more up-to-date information and resources. Beginning with this May issue, Medical Economics® will become a monthly publication filled with valuable practice management and patient care resources.

We assure you that the quality and relevance of our editorial content will remain at the highest caliber, which has been part of the Medical Economics® tradition for almost 100 years. We remain committed to helping simplify complex issues and offering useful and actionable insights wherever and whenever you need it — in print, online, video and other multimedia channels.

These changes have been made with you in mind and are truly changes that we feel will be most beneficial to you in your practice and in improving patient outcomes.

We thank you for engaging with our digital and print content, for responding to our surveys and for sharing your ideas with your colleagues to solve real business, economic and career challenges. Your loyalty and support are appreciated, and we look forward to continuing to work together.

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