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## Medical professionals seek a way out of shortage of primary care doctors accepting Medicare

[By Jocelyn Wiener - Center for California Health Care Journalism](#)

*EDITOR'S NOTE: This is the last in a three-part series entitled Collision in Care about the shortage of primary care doctors in Santa Cruz County.*

In Santa Cruz County, a storm is gathering.

Anxious elderly and disabled Medicare patients are flooding the county medical society with requests for the names of primary care doctors who might be willing to see them. They're landing in community clinics already stretched thin by the swelling ranks of the unemployed and uninsured. They're camping out in hospital emergency rooms, because they have nowhere else to go.

There simply aren't enough primary care doctors to go around.

Fed up with low reimbursement rates -- and swamped with need -- many doctors who do practice here are refusing to care for any additional Medicare patients.

With each passing day, the county's primary care shortage becomes more evident -- for the elderly, for the disabled, and for most everyone else. Officials, doctors and patients all ask: Is there a way out of this crisis?

For years, Santa Cruz County's doctors have complained that a federal "rural" designation decided half a century ago allows Medicare to reimburse them at the same low rate as their counterparts in the Central Valley, despite the fact that the cost of living here rivals Silicon Valley's. At the end of last year, the median price for a home sold in Santa Cruz County was \$425,000; in Merced County, it was \$120,000.

Many of this county's doctors say the local primary care shortage could largely be fixed if Congress would simply redefine one term -- rural.

But other experts say that, while such a change might ameliorate the county's problems, it certainly won't solve them. Even if local reimbursement rates do go up, Santa Cruz County will continue to suffer from the same primary care shortage affecting almost every other community in the nation. Studies show that, these days, less than 2 percent of medical school graduates are going into general internal medicine -- the primary care field most focused on caring for the elderly.

"We're about to head to major crisis," said Dr. Robert Berenson, a senior fellow at the Urban Institute, a Washington, D.C.-based nonpartisan think tank that specializes in economic and social policy research.

To change the tide, Berenson and other experts say, what's needed is an overhaul of the nation's increasingly fragmented, increasingly specialized health care system. The federal government will have to stop paying specialists much more for performing procedures on sick patients than it pays primary care doctors for keeping those patients healthy, they argue. That system not only hurts patients; it drives medical costs through the roof.

Few believe that money alone will solve the national primary care shortage. Some suggest the answer lies in changing medical education, including increased emphasis on primary care and relief for students' \$140,000 debts. Others assert that new technology, like electronic medical records, can reduce medical errors, improve coordination between doctors and relieve primary care physicians' workloads. Still others believe

that nurses, physician assistants and even patients themselves must take more responsibility for diagnosis and treatment of simpler health problems, like colds or strep throat, roles traditionally held by primary care doctors. That, in turn, could free those doctors up to see patients with more complex illnesses.

Some of these solutions may be feasible in the near term, helped by the recently passed federal stimulus package that promises billions of dollars to encourage adoption of health information technology, and hundreds of millions to train primary care providers and cover medical school costs for those who practice in under-served areas. Other solutions will no doubt be hindered and shaped by money, politics, special interests and even by members of the medical establishment.

As Santa Cruz struggles with its local primary care crisis, a national crisis in care looms ever darker on the horizon. On all sides of the debate, patients, doctors and politicians are coming to agree on one thing: We need solutions. And we need them soon.

### **Change the local reimbursement rate**

For many in Santa Cruz, the most obvious way to help new Medicare patients see primary care doctors would be to change the county's "rural" classification.

In the mid-1960s, when the federal Medicare system was first created, Santa Cruz was lumped in with more than 40 other "rural" California counties; doctors from Monterey to Merced were paid the same amount to see patients, regardless of cost of living.

In some of those counties -- and especially in Santa Cruz -- costs have skyrocketed. But physicians here continue to be paid about 16 percent less than their counterparts in Santa Clara. Until recently, they earned 25 percent less. Because many private insurers base their rates off of Medicare's, this means physicians get paid less across the board.

Changing that designation has been a rallying cry for many of the county's doctors. The local congressman has tried, multiple times, to introduce a legislative fix. Several counties, including Santa Cruz, filed a lawsuit in federal court two years ago. But advocates have still been unable to force through a change. Many feel hopeful the rates will finally be readjusted in the coming year, under the leadership of the new administration of President Barack Obama.

"I think we're reaching a tipping point," said Dr. Chris O'Grady, a Watsonville family practice doctor, and president of the Santa Cruz County Medical Society.

### **Reduce payment disparities**

But even if reimbursement rates do change, the problem will be far from fixed, said Dr. Berenson of the Urban Institute. The local primary care shortage is part of an emerging national crisis, he said. All over the country, primary care doctors are refusing to take on not only new Medicare patients, but also those with private insurance.

Berenson notes the example of Massachusetts, which implemented a universal health insurance program in 2007. The state has struggled without enough primary care doctors to meet the expanded demand.

Part of the problem is priorities and the money that follows. The current health care system, Berenson and others say, places a high value on tests and procedures, and a much lower value on integrated care.

"What's been terribly overvalued is doing things to people, putting scopes in people's bottoms and taking out their tonsils," said Dr. Ted Epperly, president of the American Academy of Family Physicians.

Epperly says that, while an ophthalmologist might make \$2,500 for removing a cataract, a primary care doctor is reimbursed just \$50 to \$70 to care for a patient suffering from both rheumatoid arthritis and serious depression.

What results is a sizable gap between what Medicare -- and therefore private insurance companies -- pay primary care providers, and what they pay specialists in radiology, orthopedics, anesthesia or dermatology. Because of their high rates of pay, Berenson said some medical school students use the specialties' initials to refer to the "R.O.A.D." to success.

According to the American Medical Group Association, the average internal medicine doctor in the United States earned just shy of \$200,000 last year. The average dermatologist made almost \$345,000.

Berenson says Congress can reallocate Medicare resources by trimming reimbursement for certain procedures like MRIs and CT scans, using those cost savings to pay more for what primary care doctors do best -- coordinating and managing patient care.

"Throwing money at the problem isn't everything," he said. "But it sure would help."

### **Provide medical homes**

Another solution that is gaining traction among physician and consumer groups and the business community -- "the silver bullet for the moment," according to Eleanor Littman, executive director of the Santa Cruz Health Improvement Partnership -- is the idea of the patient-centered medical home. That model pays primary care doctors extra to work with a team of case managers and nurses to provide ongoing care for patients.

Edwina Rogers, executive director of the Patient Centered Primary Care Collaborative, a lobbying coalition for the concept, says the medical home model pays primary care doctors an extra monthly fee for every patient whose health care they oversee. Some models show primary care doctors' incomes going up by as much as \$120,000 a year. That's easily enough to add on an extra clinician or case manager.

Patients get same-day appointments, and regular monitoring of chronic conditions. Primary care doctors communicate with any and all specialists, making sure -- for example -- that patients aren't being prescribed incompatible drugs. All medical records are available electronically. By keeping patients healthier -- and out of the hospital -- Rogers said the overall cost of care is actually reduced for insurers.

North Carolina recently piloted a medical home model, and saved \$1.4 billion in five years, she said.

Later this year, Rogers said, Medicare is planning to roll out an eight-state pilot of the medical home model, paying doctors an extra \$40 to \$50 per patient monthly -- sometimes more -- to oversee care.

"Doctors love it," she said. "Morale is very high. They feel like it's what they went to medical school to do."

### **Attract students to the field**

Improving primary care doctors' morale is a critical aspect of the medical home model, or of any attempt to draw more medical students into primary care.

Many medical experts, including Dr. Pat Meehan, executive director of the Santa Cruz Women's Health Center, say programs to forgive or reduce students' \$100,000 to \$200,000 medical school loans could attract more to the lower-paying primary care fields.

But to the extent that most primary care physicians must move, rapid fire, from one patient to the next, while simultaneously juggling e-mails, phone calls, pharmacy referrals, hospital rounds and a mountain of

paperwork, a simple pay increase won't be enough to attract students to the job. Many students are attracted to specialized medicine because the pace is easier, they don't have to cram in so many patients per day and they're able to develop expertise in a narrower range of medical information.

"There's a syndrome of primary care doctors feeling like hamsters on a treadmill," said Berenson of the Urban Institute.

This past fall, Dr. Karen Hauer, a professor of clinical medicine at the UC San Francisco, published a survey of 1,200 medical students in the Journal of the American Medical Association. All but a tiny fraction of those surveyed had no plans to enter primary care -- but few mentioned money as a prime motivator. Instead, they focus on things like life balance, and avoiding burnout.

"They're not choosing the specialty based on how many dollars per year it will bring in," Hauer said. "They're choosing based on where they see their role models achieving a satisfying career."

Hauer and others also emphasize that the country needs more work force planning, so that it's not simply left to individual hospitals to decide what types of residencies they will offer.

"Clearly what America doesn't need is a million dermatologists," said Epperly of the American Academy of Family Physicians. "It needs a million family physicians."

### **Reimagine the role of the primary care doctor**

While politicians, patients' advocates and physicians' groups focus on ways to draw more medical students into primary care professions, a small minority is raising the question of whether the country actually needs more primary care doctors. Maybe what's really needed, they say, is a complete restructuring of the way medical care is provided.

Dr. Arnie Milstein, medical director of the Pacific Business Group on Health, a business coalition seeking to improve health care quality while moderating cost, likes to use the metaphor of Goldilocks and the three bears.

For the many patients who come to their primary care doctors with a cold or strep throat, Milstein believes the current primary care system is "too hot." Those patients don't usually need to see a doctor at all, he says; they could get what they needed just as easily from a nurse practitioner, or even a phone or e-mail exchange.

Leaning on primary care doctors for that kind of help wastes years of training, he said.

"It's like using a tennis racket to swat a fly," he said.

At the same time, for patients with multiple serious, chronic illnesses, Milstein says the current primary care system is "too cold." They don't get enough time or attention, and their doctors often aren't skilled enough to care for them. Those patients need a highly trained team of doctors, nurses and case managers to provide intensive, ongoing management of their illnesses.

Only the third group, including those who need management of a single chronic disease, might actually fit well with the current system, and be considered "just right."

Milstein believes the current debate about the national primary care shortage places too much emphasis on paying doctors more, rarely questioning the overall model used to deliver care.

Whatever model wins out, most believe the only way to solve the problem is to make providers on the front lines feel valued. That might require more money. It might require higher job satisfaction. It will certainly require that they feel respected.

Until that happens, many patients searching for doctors in Santa Cruz County continue to struggle with one important question:

Who will take care of me now?

"People have said, what will fix the crisis in primary care, it will need to be that the crisis deepens to the point that people pay attention," said Dr. Hauer, of UCSF.

For many patients in this county, at least, that moment seems to have arrived.

Jocelyn Wiener reports for the Center for California Health Care Journalism