AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Empowering rheumatology professionals to excel in their specialty

800 Maine Avenue, SW • 6th Floor • Washington, DC 20024
Phone: (404) 633-3777 • Fax (404) 633-1870 • www.rheumatology.org

House Committee on Ways & Means Subcommittee on Health
1100 Longworth House Office Building
Washington, DC 20003

Statement of the American College of Rheumatology
Re: The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine
June 6, 2024

On behalf of the 8,500 American College of Rheumatology (ACR) members, I write in response to the May 23, 2024, Ways and Means Health Subcommittee Hearing on The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine. The ACR appreciates the opportunity to provide our feedback on the causes of the current crisis facing healthcare professionals fighting to open and maintain private practices and potential legislative solutions.

The trend of private practices having to sell to hospital systems, private equity, and other larger financial institutions was brought about by many factors. However, the ACR agrees with the panelists who spoke in front of the committee on May 23, 2024, that the combination of 1) the administrative burden of prior authorization and 2) inadequate reimbursement for providing care to Medicare patients is insurmountable for many private practices. Additionally, many private practices sell due to the growing physician workforce shortage which leaves practices with no way to meet demands or with no one to take them over when physicians retire.

1. Medicare Reimburses Less then the Cost of Care

For too long physician practices have been expected to pay high wages to their care team and other staff, and foot the bill for technology, rent, malpractice insurance, medical supplies, marketing, and legal advice on five fewer dollars from Medicare than in 2001 when those dollars are worth 105% less. In 2024 the Medicare Physician Fee Schedule (MPFS) conversion factor is $32. 74, lower than it was in 2001. If the MPFS conversion factor were tied to inflation, it would be $67.39. Additionally, under the current system of Medicare funding, there are across-the-board cuts each year to reimbursements to physicians treating Medicare patients in the MPFS. As physician-owned practices combat insecurity around varying payments from Medicare for treating patients, these patients' access to care is put at risk.

This is because a provision was included in the Omnibus Budget Reconciliation Act of 1989, which mandated that any estimated increases of $20 million or more to the MPFS—created by upward payment adjustments or the addition of new procedures or services—must be offset by cuts elsewhere. Therefore, each time a procedure code or other service is reviewed and updated to reflect the modern (higher) value the CF is cut to offset that increase.

This legislation created a trend borne of the necessity of smaller physician-owned practices merging with larger multi-specialty groups or selling to hospital systems. Other practices opt out

of the Medicare payment system and only accept private insurance or cash for services. This leaves the most vulnerable Americans, including seniors, the disabled, and those living in underserved communities disproportionately affected and with few options for medical care. As more physicians cut Medicare from their practices, Congress will have to revisit and eventually overturn the budget neutrality requirement for the MPFS.

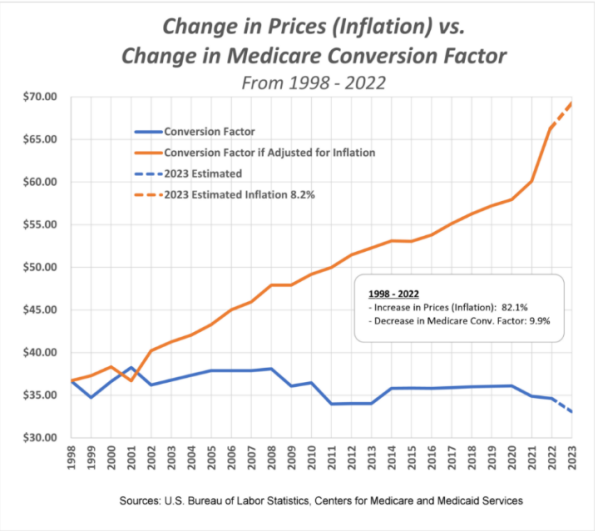
The result? Physician practices are never certain what the reimbursement rate will be each year. So, they squeeze more patients into the schedule daily to make up for the new cuts; leaving physicians and patients dissatisfied. The resulting physician burnout threatens the sustainability of medical care for all Americans and leaves groups like the American College of Rheumatology rushing to Congress annually asking to reduce or eliminate the cuts to the MPFS.

We suggest Congress avoiding putting patient care in jeopardy by passing two pieces of legislation currently before the committee.

First: Support the *Strengthening Medicare for Patients and Providers Act*, (HR 2474) to tie physician payments for treating Medicare patients to inflation by adding a permanent, Medicare Economic Index (MEI) based inflationary update to the MPFS. Physicians are the only healthcare sector that does not receive an inflation-linked increase in Medicare payments.

When inflation is factored in Medicare physician payments plunged 20% from 2001 to 2021. Over the same time, the cost of operating a practice went up 39%. HR 2474 would tie Medicare physician payments to inflation, like all other Medicare payments, and reduce the gaps between the cost of providing the care and the amount that physicians are reimbursed.

In 2024 the MPFS conversion factor is $32. 74, lower than it was in 2001. If the MPFS conversion factor were tied to inflation, it would be $67.39. Physician practices are expected to pay high wages to their support staff to keep pace with inflation, technology, supplies, rent, malpractice insurance, medical equipment, marketing, legal advice, and more on five fewer dollars than in 2001 when those dollars are worth 105% less.



Second: Support *the Provider Reimbursement Stability Act* (H.R 6371) to reduce the impact of budget neutrality requirements on the MPFS by raising the budget neutrality threshold from $20 million to $53 million, then increasing the threshold every five years to reflect the cumulative increase in the MEI and additional policies requiring increased accuracy in accounting for estimates and revisions which will lead to fewer Congressional intervention and more accurate information.

This increased flexibility to make updates without pitting MPFS code users against each other will hopefully save physicians and Congress time while more thorough reforms can be considered. In the long term, the budget neutrality requirement for MPFS is not sustainable. But in the immediate future, this legislation would more than double the amount of new spending in the MPFS before budget neutrality requires cuts.

Additionally, the ACR supports legislation:

- Canceling scheduled cuts to Medicare physician reimbursements.
- Ends the statutory freeze on Medicare physician fee payments related to inflation currently scheduled to last until 2026.
- Ask CMS to weigh the practice expense fairly, & malpractice work components across the board to reimburse providers equitably.
- Reward the value of care provided to patients, rather than administrative burdens–such as data entry–that may not be relevant to the service being provided or the patient receiving care.
- Offer a variety of voluntary payment models and incentives tailored to different specialties and practice settings while ensuring fee-for-service models remain financially viable.
- Provide timely, actionable claims data so physicians can identify and reduce avoidable costs.
- Recognize the value of clinical data registries as a tool for improving the quality of care.
- Address the adverse impact of the balanced budget requirement on physicians through the MPFS, the undervaluation of E/M services, and cognitive care services are critical steps that can mitigate the medical workforce crisis. Specifically for the rheumatology workforce, legislation should address:
    - The current MPFS system where reimbursement codes for procedures are reviewed more often than E/M codes perpetuates substantial compensation disparities at the expense of primary care physicians and cognitive specialties like rheumatology.
    - Work Relative Value Units (RVUs) which systematically depress reimbursements for clinician work.
    - Review office evaluation and management (E/M) codes reviewed as often as procedure codes (every 5-7 years) to ensure appropriate reimbursement.

2. The Burden of Prior Authorization

Prior authorization is a process requiring a medical provider prescribing treatment to obtain approval from an insurance plan before the patient can receive the prescribed treatment. This is a time-consuming process that often involves a patient going to the pharmacy and being turned away because prior authorization has not been obtained. A 2021 study shows that 71% of infusible medication prescribed to treat a rheumatic disease required prior authorization from the insurer before treatment could begin. These treatment delays negatively impacted on patients and allowed disease progression while **more than 95% of the requests were ultimately approved**. While prior authorization may have initially been intended to control costs by reducing unnecessary tests and procedures, health plans now indiscriminately use the process to initially refuse treatment to deter care and create hurdles for patients and physicians that endanger patients' health and cost practices. The process for obtaining the required approval can be lengthy and typically requires a physician or member of the care team to spend many hours each week negotiating with insurance companies—time that should be spent taking care of patients.

A recent national survey found that 87% of physicians report that prior authorization has a significant (40%) or somewhat (47%) negative impact on patients' clinical outcomes. Nearly one-third of physicians surveyed said their patients often abandon treatment due to prior authorization delays. When treatment is delayed or the patient does not return for the prescription, the consequences can be devastating, yet prior authorization can delay treatment for weeks or even months even though most requests are eventually approved—nearly 100% of some treatments. Furthermore, 84% of survey respondents said that the regulatory burdens associated with prior authorization have significantly increased over the past five years, with half of all practices reporting 11 or more requests per week.

As of August 2021, interacting with payers regarding drug utilization management, including prior authorization requirements, costs physicians $26.7 billion. According to the AMA, physicians complete an average of 40 prior authorizations per week. This administrative nightmare eats up roughly two business days (16.0 hours) per week of physician and staff time—time that should not be wasted when access to care is already limited and insurance plans cover the prescribed treatment.

If prior authorization were streamlined in the following ways, ACR members could preserve vital practice resources for patient care and would be more likely to maintain independence:

- Creating a universally accepted prior authorization form with the option to electronically submit.

- "Gold card" legislation, which creates a continuous prior authorization exemption for physicians who earn a 90% approval rate on prior authorization requests for a given service over a period of six months.
- Carrying prior authorizations for stabilizing medications over to new insurance plans.
- Eliminating additional prior authorizations for chronic patients who are stable on a specific medication or therapy by making prior authorization approvals extend for the duration of the treatment without the need for additional or annual renewal.
- Eliminating prior authorization for medications that do not have an equally effective alternative.
- Codifying exceptions to prior authorization requirements where these policies threaten patient health.
- Requiring timely appeals of prior authorization denials with standardized and published processes and determination timelines.
- Increasing transparency by insurance companies through publicizing formularies, specifying which medications require prior authorization and the specific related requirements.
- Requiring insurers to report the prior year's prior authorization approvals and denials and the accompanying timelines to respond to prior authorization requests.
- Requiring peer-to-peer reviews for prior authorization to be assigned to a physician licensed in the same or similar medical specialty.

3. The Growing Physician Workforce Shortage

According to recent projections, the U.S. will face a physician shortage of between 54,100 and 139,000 physicians by 2033, more than two of five currently active physicians will be 65 or older within that time. Forty percent of practicing physicians were feeling burned out at least once a week even before the COVID-19 crisis. The COVID-19 pandemic has exacerbated this issue as we see more burnout, retirements, and career changes from the medical field. This means the rising patient population is competing to see a shrinking pool of doctors, leading to prolonged wait times, delayed, or abandoned care and treatment, and a higher risk of disease progression and disability.

The ACR feels the weight of this issue acutely. There are an estimated 91 million Americans currently living with rheumatic disease and fewer than 5,600 active board-certified rheumatologists to treat them. By 2030, the demand for rheumatologists is projected to exceed supply by over 4,700 rheumatologists as the prevalence of rheumatic disease in our population continues to grow. Many practices currently report at least a six-month wait time to see new patients with rheumatic disease, during which the disease advances.

The care of rheumatology patients requires an interprofessional team consisting of rheumatologists, nurse practitioners, physician assistants, clinic and infusion nurses, pharmacists, rehabilitation specialists, mental health and social workers, and researchers developing new therapies and evaluating clinical services. The healthcare workforce shortage, burnout, research, and education funding challenges, and reimbursement obstacles have affected all members of the rheumatologic interprofessional team, and the ACR supports legislative solutions addressing these issues.

Drivers of the Healthcare Workforce Shortage

There are currently many geographical areas of the United States with limited or no access to a rheumatologist or rheumatology care provider, a trend expected to significantly worsen in the coming decades according to the latest Rheumatology Workforce Study. There is a predicted shortage of 3,845 rheumatologists in the U.S. by 2025, up from previous projections of 2,576. Recent figures suggest that arthritis may be even more common than previously estimated, with an estimated 91.2 million Americans affected in 2015, and the cases are rising.

Additionally, the availability of pediatric rheumatologists is at a crisis level, with fewer than 400 pediatric rheumatologists in the United States providing care at present. Nine states do not have a single board-certified, practicing pediatric rheumatologist and six states only have one. As a result, many children and adolescents with pediatric rheumatic diseases have limited access to high-quality care for their conditions. Rheumatologists trained to care for adult patients do not have sufficient training to provide the highest quality care for pediatric patients while general pediatricians have not received adequate training to treat the intricacies of pediatric rheumatology conditions.

Limited Training Opportunities

The current physician pipeline is being artificially narrowed by the limited number of medical school and postgraduate training slots. The number of residency and fellowship positions has not kept pace with either the number of medical school graduates or the demand for physicians. These numbers are one factor in the decline in medical school enrollment as students do not feel certain they will have access to the necessary training to practice medicine even after graduating from and paying for medical school. Pipelines suggest medical students are growing in number; however, the filling of training positions varies by availability. In adult rheumatology, there are more applications than positions, and in pediatrics, most positions do not fill.

Unfortunately, over 20 years ago, the Balanced Budget Act of 1997 imposed caps on the number of residents for each teaching hospital eligible to receive Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. These caps have remained in place and have generally only been adjusted as a result of certain limited, one-time programs despite the growing medical workforce shortage. Congress increased the number of Medicare-supported GME positions by 1,000 in the Consolidated Appropriations Act, 2021—the first increase since 1997, nearly 25 years ago. The slots are distributed by the Centers for Medicare and Medicaid Services (CMS) through rulemaking.

While the 1,000 positions recently provided by Congress are an important start to training more physicians, additional support is needed and it should be targeted. Even while Medicare supports physician training by funding GME training positions for specialty care including rheumatology, **nine states still do not have any adult rheumatology fellowship positions and twenty-eight states do not have any pediatric fellowship positions**.

Legislative Solutions to the Limited Training Opportunities

We are simply not providing enough opportunities for medical school graduates to receive training to participate in the medical workforce. To expand the pipeline of new physicians ready to treat patients, Congress needs to fund more GME slots. Although shortfalls, only partially addressed by the 1,000 slots added by the 116th Congress, will affect all Americans, the most vulnerable populations, particularly those in rural and underserved areas, disproportionally feel the impact of the deficit. We are particularly concerned for our seniors because, as the numbers of new Medicare enrollees grow, so does their need for and utilization of healthcare services.

The geographic location of training positions also requires careful consideration. There is currently a maldistribution of physicians including rheumatologists across the country, with many areas, particularly rural areas, having fewer physicians per capita than urban areas.

The ACR believes that residency programs are an important part of medical education, providing hands-on training for medical school graduates. Congress can provide additional funding to expand residency programs, particularly in underserved areas. GME is a necessary public good that must be protected and increased funding is necessary to support a healthcare workforce capable of meeting the needs of America's patient population. **One thousand additional positions represent a step in the right direction but are too few to meaningfully impact the physician shortage. Medicare needs to increase funding for DGME and IME training positions.** Congress should also increase federal funding for nursing education, to address the national nursing shortage and increase the numbers of advanced practice nurses.

Healthcare Workforce Burnout and Early Retirement

The practice of medicine and delivery of healthcare services can be highly demanding and stressful, which can contribute to burnout and early retirement. Newly published research shows that the COVID-19 pandemic accelerated the physician burnout rate. At the end of 2021, nearly 63% of physicians reported symptoms of burnout, up from 38% in 2020. Research shows that large-scale change is needed to address the physician burnout crisis and mitigate the impact of physician retirements on the medical workforce shortage.

Before COVID-19, two main factors were thought to drive physician and advanced practice provider (APP) burnout and early retirement. The first is changes in healthcare delivery. The healthcare industry is constantly evolving, and many providers feel that they are no longer able to practice patient-focused medicine or care for patients in the way that motivated them to pursue medicine as a career in the first place. Healthcare delivery models, such as the rise of electronic health records, the increasingly complex Quality Payment Program requirements, and increased administrative burden, have reduced time with patients and contributed to burnout and early retirement.

The second is that physicians and APPs may retire earlier or transition out of direct patient care if they feel that the potential earnings are no longer worth the cost to them to work or maintain a practice. Declining reimbursement rates and the rising cost of operating a business increase the incentives to sell private practices to larger companies or simply shut down altogether, with a dramatic impact on the community and patients that the practice served.

Legislative Solutions to Physician Burnout and Early Retirement

The ACR supports confidentiality laws that protect physicians and other healthcare providers seeking help for wellness, burnout, and fatigue and removal of inappropriate, stigmatizing questions on licensure and renewal applications. Additionally, health systems and academic medical institutions should remove questions on credentialing and other applications that might prevent physicians, residents, medical students, and other applicants seeking hospital privileges from seeking care for mental wellness.

Policymakers need to address the inordinate amount of time that physicians and other clinicians spend on documentation during patient interactions. **Future legislation should aim to reduce this burden and provide healthcare professionals with more time with patients, rather than paperwork**. The ACR would like to see incentives to ensure that EHR providers, coders, payors, and other vendors implement simplified coding, so providers no longer labor under undue documentation complexity.

Economic Barriers to the Medical Workforce

Medical Education Debt

The cost of graduate-level medical education is substantial for most students. In addition, the economic realities of practicing medicine in the United States have evolved away from the assurance of prosperity that used to be associated with the profession. In addition to the cost of medical education, which can discourage some college students from pursuing a career in medicine, this also affects those already carrying heavy debt from undergraduate education.

Further, those who must undertake several years of residency with very low pay are often unable to begin repaying student debt immediately. As a result, they qualify to have their payments halted during residency through deferment or forbearance processes, but they continue to accrue interest that is added to their balance. The accrual of interest on substantial debt compounds financial concerns. This interest increases the amount of the loan during each year of training, growing the debt for years before a physician is fully trained and able to begin repaying student loan debt.

Legislative Solutions to Mitigate the Impact of Education Debt

It is important to note that rheumatologists and other cognitive specialists are currently excluded from most federal and state public loan forgiveness programs, which prioritize primary care physicians. However, like primary care physicians, rheumatologists and other cognitive specialists provide ongoing care to patients. Rheumatologists and other cognitive specialists primarily bill evaluation and management (E&M) codes and often serve as a principal providers of care for their patients. Therefore, the ACR supports establishing loan forgiveness programs that would encourage cognitive specialists to practice in underserved areas or expanding the application of the current programs to include cognitive specialties.

The ACR also supports legislation that would **allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program**. Currently, the REDI Act (HR 1202) would prevent physicians and dentists from being penalized during residency by precluding the government from charging them interest on their loans during a time when they are unable to afford payments on the principal. The REDI Act does not provide any loan forgiveness or reduce a borrower's original loan balance but recognizes the specific circumstances of those pursuing a medical career.

Limited Access to Workforce for Visa Holders

Immigrants represent disproportionately high shares of U.S. workers in healthcare—a fact underscored during the coronavirus pandemic as the foreign-born have played a significant role in frontline pandemic-response sectors. In 2018, more than 2.6 million immigrants, including 314,000 refugees, were employed as healthcare workers, with 1.5 million of them working as doctors, registered nurses, and pharmacists. Even as immigrants represent 17 percent of the overall U.S. civilian workforce, they are 28 percent of physicians.

Currently, 34,000 Deferred Action for Childhood Arrivals (DACA) recipients – physicians, nurses, dentists, and many others - provide health care to patients in communities across the nation. Meanwhile, the Health Resources and Services Administration (HRSA) estimates that 99 million Americans live in primary care Health Professional Shortage Areas (HPSAs). To put it in perspective, at least 17,000 primary care practitioners would be needed to serve these areas to eliminate their shortage designation. Health professionals with DACA status encompass a diverse, multiethnic population, who are often bilingual and more likely to practice in rural and underserved communities. They are practitioners who provide a tremendous resource to patients who often have challenges with access to health care services or with communication barriers.

According to a 2019 survey of DACA recipients interested in health careers, 97% expressed plans to ultimately work in the neighborhoods in which they grew up, or other underserved areas. That number is consistent with other studies demonstrating that underrepresented individuals in health professions are twice as likely to pursue careers working with underserved populations. Recent court rulings have left the DACA program in legal limbo.

The H-1B visa is for temporary workers in specialty occupations who hold professional-level degrees. It does not have a two-year home residence requirement. The H-1B visa allows a foreign national to enter the U.S. for professional-level employment for up to six years. The H-1B visa is available to graduates of foreign medical schools who have passed the necessary examinations, have a license or other authorization required by the state of practice, and have an unrestricted license to practice medicine or have graduated from a foreign or U.S. medical school.

Currently, J-1 visa-holding resident physicians from other countries training in the US are required to return to their home country for two years after their residency has ended before they can apply for a work visa or green card to work in the US. The Conrad 30 program allows these physicians to remain in the US without having to return home for two years if they agree to practice in a medically underserved area for three years. The Conrad 30 program helps physicians who are educated and trained in the US continue to serve in our medical workforce.

Legislative Solutions to Clearing the Path for Visa-Holding Physicians

International Medical Graduates who seek entry into U.S. programs of Graduate Medical Education (GME) must obtain a visa that permits clinical training to provide medical services. Nearly one-fourth of the active U.S. physician workforce are foreign graduates and international medical graduates (IMG). Nonimmigrant or immigrant visas are needed for IMG physicians and healthcare professionals to legally practice in the U.S. when they are not U.S. citizens. The proportion of residency programs sponsoring H-1B visas for training has gradually decreased in the last few years as the immigration requirements are multistep, costly (for the employer), and often complicated with bureaucratic immigration nuances. **To support the healthcare workforce, future legislation should facilitate easier access to more visas for those seeking roles in the US medical workforce.**

In light of these nationwide health workforce shortages, the DACA program and its corresponding work authorizations are critical to retaining and expanding our nation's health workforce and healthcare capacity. Further:

- The ACR supports the expansion of the Conrad 30 waiver program to allow more J-1 foreign medical graduates to apply for a waiver of the 2-year foreign residence requirement upon completion of the J-1 exchange visitor program.
- The ACR supports legislation that would reallocate unused visas for IMGs to ensure durable immigration status for these medical professionals.

4. Conclusion

Private practices are essential to our communities and should be supported by policy. First, Medicare should reimburse physicians for the actual cost of providing care to patients in that system. Second, payers should not be allowed to drown providers in expensive arbitrary hurdles to deter care. Third, to keep practices viable, Congress needs to support the physician workforce.

The ACR looks forward to partnering with the Ways & Means Health subcommittee as legislative solutions are considered. Please contact Lennie McDaniel, JD, Director of Congressional Affairs, at LMcDaniel@rheumatology.org should you have any questions or need additional information from the ACR or its membership.