AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

Empowering rheumatology professionals to excel in their specialty

1800 M Street, NW • Suite 740S • Washington, DC 20036
Phone: (404) 633-3777 • Fax (404) 633-1870 • www.rheumatology.org

March 20, 2023

The Honorable Bernard Sanders
Chair, Health, Education, Labor & Pensions Committee
32 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy, MD
Ranking Member, Health, Education, Labor & Pensions Committee
455 Dirksen Senate Office Building
Washington, D.C. 20510

On behalf of the 7,700 members of the American College of Rheumatology (ACR), I write to provide comments in response to your Request for Information on the Healthcare Workforce Shortages, dated March 2, 2023. The ACR appreciates the opportunity to provide our feedback on the causes of our current healthcare workforce shortages and potential legislative solutions.

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.

I. 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.

II. 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.

Prior to 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.

III. Economic Barriers to the Medical Workforce

A. 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

First, the ACR supports the maintenance and growth of programs offering student loan debt assistance to those pursuing careers in medicine:

> The Public Student Loan Forgiveness Act (PSLF) addresses the rheumatology workforce shortage in two ways. First, the program encourages young physicians to choose rheumatology despite the relatively lower compensation than other areas of medicine. Second, it encourages new fellowship graduates to remain at academic medical centers

and train the next generation of rheumatologists rather than accepting a potentially higher-paid position in private practice.

Unfortunately, in 2018 and 2019, in the first group of applications for forgiveness under this program, more than 99% were denied. However, recently, more applicants are receiving their loan forgiveness through the PSLF program, a trend the ACR hopes to see continue.

Similarly, the Pediatric Subspecialty Loan Repayment Program (PSLRP) specifically addresses the pediatric rheumatology workforce by encouraging pediatricians to pursue additional subspecialty training, despite the lower compensation compared to general medical practice, through loan forgiveness opportunities.

This program was funded in FY2022 by the 117th Congress for the first time since its authorization by Congress in 2010. With the approved $5 million, it is estimated that approximately 50 initial two-year awards will become available. While this is an important first step, the ACR supports funding this program at $30 million per year to increase access to specialty care in underserved communities and make training and careers in vital medical specialties an easier choice.

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 care provider 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 (S. 704) 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.

B. Medicare Reimbursement Rates

The current system for reimbursing physicians who treat Medicare patients is unsustainable and requires reform to secure a medical workforce and protect patient access to quality, evidence-based care. Medicare rates influence the value placed on medical care throughout our system. With inflation, **Medicare physician payments have plunged 20%** from 2001 to 2021 while during the same time, the **cost of operating a practice has gone up 39%.**

Medicare reimbursements through the Medicare Physician Fee Schedule (MPFS) were cut in 2022 and again on January 1, 2023. Physician practices are feeling the impact of inflation while still dealing with pandemic-related financial issues. Additionally, added cost is estimated at $12,811 and more than 200 hours per physician annually to comply with the current Medicare Merit-Based Incentive Payment System.

While all physicians are subject to these cuts, the MPFS structurally prioritizes procedures at the expense of cognitive care – compounding the impact on rheumatologists. "Evaluation & management" visits (E/M), which make up a large share of the services provided by primary care clinicians and other specialties like rheumatology, have historically been underpriced in the MPFS relative to other services, according to MedPAC, and due to the structure of the MPFS "have become passively devalued over time".

Legislative Solutions to Issues with Medicare Reimbursement Rates

The ACR supports legislation canceling scheduled cuts to Medicare physician reimbursements and that:

- Ends the statutory freeze on Medicare physician fee payments related to inflation currently scheduled to last until 2026.
- Provides an inflation-based update to MPFS for the full MEI.
- 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.

Further, more broad, structural changes to the reimbursement system that 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.

IV. 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

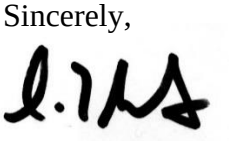
healthcare professionals to legally practice in the U.S. when they are not U.S. citizens. The proportion of residency programs sponsoring H-1B visas for training has gradually decreased in the last few years as the immigration requirements are multistep, costly (for the employer), and often complicated 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.

We look forward to partnering with the HELP committee as solutions are considered and developed. Please contact Lennie Shewmaker 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.

Sincerely,



Douglas White, MD, PhD
President, American College of Rheumatology