CHAPTER 3:

Fixing Physician Reimbursement and Workforce Shortages: Diagnosis, Prescription, and Treatment

FIXING PHYSICIAN REIMBURSEMENT AND WORKFORCE SHORTAGES: DIAGNOSIS

Trend: Outdated reimbursement models without inflation adjustments, continuous reimbursement cuts, and increasing bureaucratic barriers to patient care are accelerating physician burnout and driving many physicians out of independent practice. Since 2019, over 100,000 physicians have left private practice for hospital or corporate employment.[35] Regular reimbursement cuts to the MPFS, exacerbated by the ongoing Medicare sequester payment cut, have resulted in Medicare payments effectively lagging inflation by 28 percent over the last decade.[36] The result has been an unsustainable environment for many independent practices, leading to many closures and hospital mergers. Burnout is not only worsened by declining reimbursements but also by disputes with insurers/PBMs and excessive time spent on bureaucratic tasks such as prior authorization and data entry over clinical care.[37] [38]

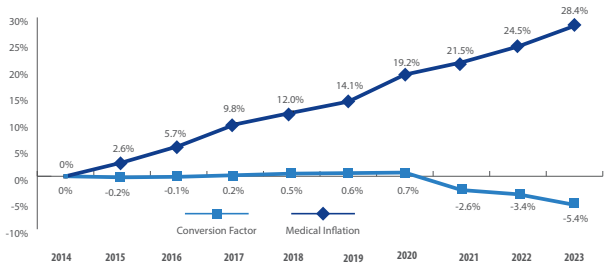
Patient Impact: Outdated Medicare policies have contributed to a wave of independent community oncology practice closures, forcing patients with cancer into larger health systems where treatment costs are markedly higher.[39] Lower reimbursement may result in fewer physicians caring for Medicare patients, resulting in longer wait times and delays in care, which are linked to poorer outcomes.[40] Rural areas are disproportionately affected and patients have increased travel burdens when clinics close. Satellite clinic closures create "medical care deserts" that significantly limit timely access to cancer care and exacerbate disparities in cancer care.[41] [42] For both patients and physicians, these closures disrupt the continuity and quality of care, making it increasingly difficult to deliver the timely, modern, patient-centered treatment essential for improved outcomes.[43]

The Facts: There is a Widening Gap Between Physician Reimbursement and the Cost of Providing Care

Physician Reimbursement Has Not Kept Pace With Inflation

The viability of independent physician practices is threatened by the continued decline in physician payment, which is true of all medical specialties, including primary care. In oncology, for example, an Avalere analysis found that from 2014 to 2023, the Medicare conversion factor decreased by a total of five percent, while the compounded increase of inflation over the same period was 28 percent.The gap between the rate of change of inflation and the conversion factor has resulted in dramatic physician underpayment over the last decade.[i]

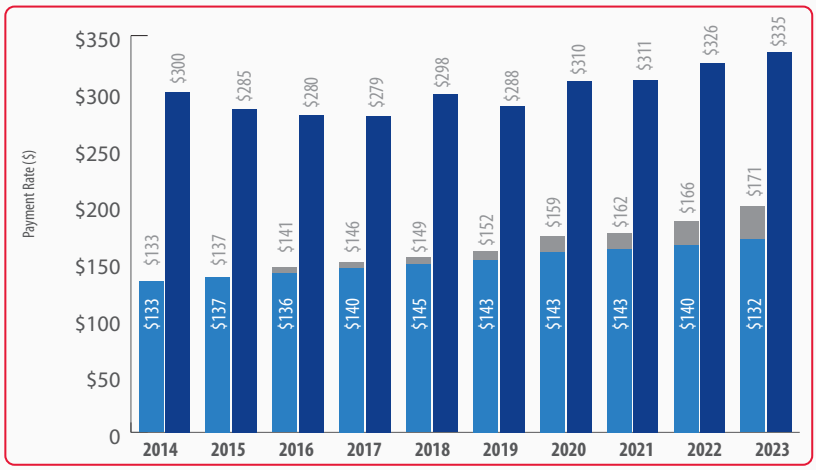
Figure 5: Physician Payment for Some Services Lags Behind Inflation[i]



Chemotherapy Reimbursement Diverges Over Time Based on Setting of Care

In 2023, physician payment for chemotherapy administration was nearly the same as 10 years ago ($133 in 2014 and $132 in 2023), while the hospital rate has increased by 11 percent during the same period. If chemotherapy administration reimbursement had kept pace with inflation in the physician office setting, it would have been $171 in 2023, and even still, this would only equal about half of the payment to hospitals ($333)[i]

Figure 6: Inflation Adjusted Physician and Hospital Payment for 1 Hour Chemo Intravenous Infusion (Code 96413), 2014-2023[i]



Note: Payment represents the non-facility physician rate; hospital outpatient represents OPPS APC rate. Avalere calculated the projected, inflation adjusted physician payment by applying the rate of change of medical inflation to the prior payment.

The ever-widening gap between reimbursement rates and expenses threatens independent oncology practices' financial viability and ability to maintain high-quality patient care.

These dynamics have continued since 2023 and will continue to catalyze closures of independent community oncology practices, shifting more cancer care to the costly hospital setting. This threatens patient access to critical care and increases health care costs, for both patients and taxpayers.

Sources:

i. *Le, Caroline, et al. "Physician Payment for Some Services Lags behind Inflation." Avalere. 11 September 2023. https://avalere.com/insights/physician-payment-for-some-services-lags-behind-inflation*

FIXING PHYSICIAN REIMBURSEMENT AND WORKFORCE SHORTAGES: PRESCRIPTION AND TREATMENT

The 119th Congress must reverse the trend of falling physician reimbursement and address workforce shortages with sustainable policy solutions.

Fix Physician Reimbursement

- Stop the continuous annual reimbursement cuts to the MPFS by incorporating factors that reflect rising real practice costs and are not currently included in Relative Value Units (RVUs), such as administrative work.
- Implement an annual Medicare Economic Index (MEI) increase to physician payment to address inflation and ensure practice sustainability.
- Eliminate the Medicare sequester reduction for independent physician practices to prevent further financial strain.
- Mandate real-time payment processing from CMS FFS carriers and MA plans to improve cash flow and reduce administrative burdens.
- Provide stable, predictable, inflation-adjusted payments that align reimbursement with clinical guidelines through the advancement of physician-driven value-based payment models that reform reimbursement for capital-intensive medical specialties, such as radiation oncology.
- Remove the budget neutrality requirement or increase the threshold to $100 million. Congress should consider a different budget neutrality structure that accounts for the broader drivers of Medicare spending that exist across payment systems, both independent practices and hospitals.
- Note that paying for increasing physician reimbursement and indexing it to inflation can be offset by site-neutral payments and lowered 340B hospital reimbursement (exempting rural hospitals). What this does, in effect, is create ecosystem equilibrium between the less expensive physician practice setting and the more expensive hospital setting.

Address Workforce Shortages

- Increase the number of Medicare-supported residency positions to stem the looming physician workforce shortage crisis, particularly in oncology. Allow Medicare funding to follow residents and fellows to accredited, non-hospital-based clinic sites.
- Implement physician and nurse incentive programs for community practices, especially rural practices, such as tuition forgiveness and loan repayment.
- Decrease the requirements for physicians from accepted foreign medical schools to practice in the U.S. and increase the availability of Conrad 30 waivers as a strategy for mitigating the shortage of qualified doctors in Health Professional Shortage Areas (HPSA), Medically Underserved Areas (MUA), or Medically Underserved Populations (MUP).
- Require HHS to apply the updated definitions of "commercially reasonable" and "fair market value" as established in the CMS Final Rule "Medicare Program: Modernizing and Clarifying the Physician Self-Referral Regulations."[44] These key definitions, which are foundational to compliance with the Federal Physician Self-Referral Law (commonly referred to as the "Stark Law"), are not being applied during the review of certain hiring practices by hospitals. If these definitions are not properly applied, hospitals will continue to violate the Stark Law because payments to employed providers are not commercially reasonable and/or not consistent with fair market value. This will continue to fuel consolidation and increase costs to patients and the health care system.

Increase Rural Reimbursement Rates

- Adjust payment models to compensate rural physicians and practices adequately, recognizing the unique challenges and higher costs of delivering care to patients and regions with fewer resources.
- Adjust technical revenue to reflect market usage to ensure the adequacy of payment for radiation and imaging services across both rural and underserved urban regions.

FIXING PHYSICIAN REIMBURSEMENT AND WORKFORCE SHORTAGES: ONGOING TREATMENT

The 120th Congress and beyond must ensure that the physician workforce will be healthy and thriving for years to come in order to meet the needs of Americans.

Address Workforce Shortages

- Expand the number of Medicare-supported medical residency positions, particularly in critical specialties like oncology, internal medicine, and general surgery.
- Provide tax credits and financial incentives to independent physicians who establish practices in rural or underserved urban areas.