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Physician Reimbursement, Impending Shortages,
and Healthcare Reform

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I. INTRODUCTION

Primary care physicians (PCPs) can serve a vital role in the lives of their patients. PCPs are often the first stop when patients have any healthcare concerns, and for some patients, have also become the gateway to every other type of specialty care. However, the supply of PCPs is increasingly unable to meet patient care needs. Largely overshadowed by the crisis of rising healthcare costs in the U.S. is the lack of PCPs who accept Medicaid patients.¹ The federal government has studied the distribution of PCPs and determined that, as of September 2011, it would take nearly 18,000 practitioners to meet the needs of Health Professional Shortage Areas (HPSAs), regions that are lacking in PCPs and other healthcare professionals to satisfy the current demand.² Given the limited supply of PCPs, the time they spend with patients has become more sought after and, consequently, more

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¹ Tricia McGinnis, Julia Berenzon, & Nikki Highsmith, *Increasing Primary Care Rates, Maximizing Medicaid Access and Quality*, CTR. FOR HEALTH CARE STRATEGIES, INC., 1, 2 (2011), available at http://www.chcs.org/usr_doc/PCP_Rate_Increase_Issue_Brief_FINAL.pdf.

² *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations*, Health Resources and Service Administration (HRSA), available at <http://bhpr.hrsa.gov/shortage/>.

difficult to obtain.³ The Patient Protection and Affordable Care Act (PPACA) has brought the issue of PCP shortage to the national headlines as its implementation looms and preparations to satisfy patient care demands seem insufficient.

The shortage of physicians affects everyone who seeks healthcare, especially individuals in rural areas or those insured by government programs such as Medicare and Medicaid.⁴ Over sixty million Americans rely on Medicaid as a source of health insurance.⁵ Of these, the geriatric population is anticipated to represent a significant portion of Medicaid recipients. It is estimated that by 2012, nearly 10,000 Americans will turn 65 years old everyday and by the year 2030, twenty percent of the population will be 65 and over, constituting half of physician visits and hospital stays.⁶ In order to minimize the impact of the PCP shortage, changes must be implemented immediately to ensure that individuals are not faced with a lack of adequate healthcare. This paper will first discuss medical training and how medical students are drifting from seeking a career in primary care to more lucrative specialties. Second, this paper will address how nurses and foreign physicians could help, and how regardless of a shortage, quality of care must be monitored at a high standard. Finally, this paper will review the changes detailed in the PPACA that provide incentives for PCPs to continue to see Medicaid patients. If these programs are adopted and implemented, the shortage of PCPs may be at least partially addressed and quality healthcare for all brought more within reach.

II. AN IMPENDING SHORTAGE OF PHYSICIANS

In 2008, the total number of active medical doctors in the U.S. was

³ McGinnis, *supra* note 1.

⁴ Stephanie Gunselman, *The Conrad "State-30" Program: A Temporary Relief to the U.S. Shortage of Physicians or a Contributor to the Brain Drain?*, 5 J. HEALTH & BIOMEDICAL L. 91, 95-96 (2009).

⁵ Deborah Bachrach, *Payment Reform: Creating a Sustainable Future for Medicaid*, CENTER FOR HEALTH CARE STRATEGIES, INC., 1, http://www.chcs.org/usr_doc/Medicaid_Payment_Reform_Brief.pdf (last visited September 30, 2011).

784,199, with 305,264 specializing in general primary care, which includes general practice, internal medicine, obstetrics, and pediatrics.⁷ Of the general primary care specialists, only 93,761 were in general practice or family medicine.⁸ The highest numbers of physicians were in internal medicine, with lesser numbers in primary care and pediatrics.⁹ Medical school graduates are bypassing careers in primary care for higher paying jobs with shorter work hours in specialty and sub-specialty areas.¹⁰ Specializations are known to pay more lucrative salaries, which help to offset the increasing costs of attending medical school in the U.S.¹¹

III. MEDICAL TRAINING

To determine the cause of the increasing shortage of PCPs - an increasingly worrisome phenomenon given the challenges and hopes of upcoming health reform - it is worthwhile to focus on medical school training, the cornerstone of every physician's career. It is expected that by 2025 there will be a shortage of 45,400 PCPs.¹² The Association of American Medical Colleges has estimated a need for a thirty percent increase in medical school enrollment by 2015 to produce approximately 5,000 new Medical Doctors annually.¹³ Unfortunately, medical school is demanding, expensive, and time-consuming. According to the American Medical Association, the av-

⁶ Fitzhugh Mullan, et al., *Aging, Primary Care, and Self-Sufficiency: Health Care Workforce Challenges Ahead*, 36 J.L. MED. & ETHICS 703, 704 (2008).

⁷ National Center for Health Statistics. Health, United States, 2010. Table 108. *Doctors of medicine in primary care, by specialty: United States and outlying U.S. areas, selected years 1949-2008*.

⁸ *Id.*

⁹ National Center for Health Statistics. Health, United States, 2010. Table 107. *Doctors of medicine, by place of medical education and activity: United States and outlying U.S. areas, selected years 1975-2008*.

¹⁰ Mullan, *supra* note 6, at 705.

¹¹ Gunselman, *supra* note 4, at 94.

¹² *The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025*, ASS'N OF MEDICAL COLLEGES, https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf (last visited September 29, 2011).

¹³ *See Physician Shortages and the Medically Underserved*, COUNCIL OF STATE GOVERNMENTS (August 2009), http://www.csg.org/knowledgecenter/docs/TIA_PhysicianShortage_Final_screen.pdf.

erage educational debt of a medical student in 2010 was \$157,944.¹⁴ Furthermore, once a student has graduated from medical school, an essential part of a physician's education, as well as a requirement for licensure, is residency training, which has not received financial support from Medicare since a cap was placed on funding in 1997.¹⁵ A recent initiative is the Affordable Care Act Primary Care Residency Expansion Program, which provided \$168 million in grant funding in 2010 and will continue to provide grants through 2014, to increase the number of physicians trained in family medicine.¹⁶ This funding includes providing \$80,000 per resident per year for those choosing residency training in family medicine.¹⁷ Additionally, partial loan forgiveness or even forgoing interest payments on federal loans will be a persuasive incentive for graduate medical students deciding on whether they will pursue a specialty or primary care.¹⁸

Aside from the detrimental effect of medical student financial concerns on the choice of a career in primary care, the long duration of a physician's required education and training, typically taking seven years or more, also contributes to the inability to meet the increasing demand for PCPs.¹⁹ As awareness increases regarding the inadequate supply of physicians to meet the high demand for their services, alternative approaches such as new incentives for medical students to choose a primary care practice and the use of physician assistants and nurse practitioners (mid-level providers) may

¹⁴ *Medical Student Debt*, AMERICAN MEDICAL ASS'N, <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/advocacy-policy/medical-student-debt/background.page?> (last visited September 28, 2011).

¹⁵ *Physician Shortages to Worsen Without Increases in Residency*, ASS'N OF AMERICAN MEDICAL COLLEGES, Section on Data and Analysis, https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf (last visited Sept. 8, 2011) [hereinafter *Physician Shortages*].

¹⁶ "Affordable Care Act (ACA) Primary Residency Expansion Program". Public Health Service Act (PL 111-148, July 2, 2010) Text from: *Catalog of Federal Domestic Assistance*, available at <https://www.cfda.gov/?s=program&mode=form&tab=step1&id=60b24aff018b4e16ac048cd2d9bd6a65>. (last visited on September 8, 2011).

¹⁷ *Id.*

¹⁸ Gunselman, *supra* note 4, at 106.

¹⁹ *Physician Shortages*, *supra* note 15.

alleviate some of the problem.²⁰ “Task shifting” is a term used to describe the development of practice strategies and educational policies to assign certain clinical tasks to be assigned to lesser-trained practitioners, allowing physicians to focus on duties for which they are uniquely qualified.²¹ In this way, patients can still be treated by qualified individuals through an equal distribution of tasks within the healthcare workforce. Additionally, physicians may work in collaboration with these mid-level practitioners in hospital and clinic settings and still be reimbursed by participating in shared/split visits, which requires both parties to have a face-to-face encounter with a patient of a substantive nature.²² This lessens the responsibility of patient examination and testing by distributing it to both parties.

Although all states face some physician shortage, there is a serious concern regarding rural areas where the shortage is especially severe.²³ While twenty percent of the U.S. population resides in rural areas, only nine percent of physicians practice there.²⁴ Sixty million people, or almost one-fifth of the country’s population, reside in one of 3,000 Health Professional Shortage Areas, which have population-to-primary care physician ratios of more than 3,500-to-1.²⁵ Rural areas are often less appealing to physicians and more difficult to staff because of less competitive salaries, less technological advancement, and geographical and security issues.²⁶ An approach to helping meet this physician demand in rural areas is the use of international medical graduates.²⁷ The Conrad “State 30” Program, initiated by Congress in 1994, provides states with visa waivers to bring up to thirty foreign physicians to practice in Medically Underserved Areas.²⁸ The J-1 visa waiver allows recipients to bypass the normal requirement of returning

²⁰ Mullan, *supra* note 6, at 705.

²¹ *Id.* at 706.

²² Lori-Ann Rickard, *Helping Clients Increase Profits Through the Use of Non-Physician Practitioners*, 21 NO. 5 HEALTH L. 44, 45 (2009).

²³ *Physician Shortages and the Medically Underserved*, *supra* note 13.

²⁴ Gunselman, *supra* note 4, at 95.

²⁵ *Physician Shortages and the Medically Underserved*, *supra* note 13.

²⁶ Gunselman, *supra* note 4, at 96.

²⁷ Mullan, *supra* note 6, at 706.

to their countries of nationality for two years after completing medical school.²⁹ A physician sponsored by a federal or state government under this program is permitted to practice in a federally designated Health Professional Shortage Area or Medically Underserved Area.³⁰ The use of such creative approaches may alleviate some of the physician shortage. However, the need to maintain an adequate number of physicians willing to serve Medicaid clients and the need to increase the number of students entering the primary care workforce remain priorities without an adequate solution.

IV. REIMBURSEMENT INCENTIVES

Aside from the increasing shortage of PCPs for patients and areas in need, the other critical issue relevant to the expected changes from the implementation of the PPACA is how modifications to physician reimbursement will affect the number of Medicaid providers. With the ongoing Medicaid reforms, an estimated thirty-two million newly eligible Americans will be entering the Medicaid system and will likely need a primary care physician.³¹ Medicaid is jointly financed by the federal government and the individual states, yet it is left to the state's discretion as to what their physician reimbursements rates will be, as long as they are within Title XIX ceiling and floor amounts on payments.³² Medicaid represents seventy percent of state health expenditures and is one of the largest costs in every state budget.³³ The Medicaid Act "equal access provision" requires that payments to Medicaid providers be "consistent with efficiency, economy, and quality of care. . ." and suffice to give Medicaid recipients the same or equal access to healthcare as those who are privately insured.³⁴

Medicaid has had the lowest physician payment rates within the U.S.

²⁸ Gurselman, *supra* note 4, at 92.

²⁹ *Id.*

³⁰ *Physician Shortages and the Medically Underserved*, *supra* note 13.

³¹ Bachrach, *supra* note 5, at 1.

³² Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 676-677 (2006).

³³ Bachrach, *supra* note 5, at 3.

³⁴ Moncrieff, *supra* note 32, at 677.

health care system, and as a result, many physicians have been reluctant to accept Medicaid patients into their practices.³⁵ Medicaid pays physicians approximately seventy-two percent of Medicare rates, and only sixty-six percent of Medicare rates for primary care services.³⁶ Unfortunately, due to Medicaid's more common fee-for-service payment model, physicians often prioritize volume and the reimbursement value of services, rather than quality of care.³⁷ On the other hand, Medicaid's managed care plans are closer to Medicare levels and therefore, attract more physicians to participate.³⁸ Ultimately, "Medicare and Medicaid are infamous for low reimbursement levels and hassling paperwork and, therefore, discourage physicians from working in areas with large Medicare and Medicaid populations."³⁹

In order to accommodate the rise in number of patients, in combination with the increasing aging population, the PPACA constructs a set of measures that incentivize physician participation. The PPACA's insurance provisions intend to expand the availability of insurance to a greater number of patients, while appropriately reimbursing physicians for this surplus of patient care without offsetting government expenditures to maintain the health insurance expansion.⁴⁰ First, Medicaid payments to PCPs for primary care services may not be lower than the Medicare fee schedule for calendar year 2013.⁴¹ Additionally, the Medicare Incentive Payment Program allows for a ten percent bonus, quarterly or annual, if primary care services approximate at least sixty percent of allowed charges by the primary care practitioners from 2011 to 2015.⁴² This ten percent bonus will be "calculated based on where the service is performed and what Medicare actually

³⁵ Stephen Zuckerman & Robert Berenson, *How Will Physicians Be Affected by Health Care Reform? Timely Analysis of Immediate Health Policy Issues*, URBAN INSTITUTE, July 2010.

³⁶ Stephen Zuckerman, et al., *Trends in Medicaid Physician Fees, 2003-2008*, HEALTH AFFAIRS, w510 - w515 (2009).

³⁷ Bachrach, *supra* note 5, at 6.

³⁸ *Id.* at 7.

³⁹ Gunselman, *supra* note 4, at 96.

⁴⁰ Emily Jane Cook, *Pay Back*, L.A. LAWYER 20, 24 (2010).

⁴¹ The Henry J. Kaiser Family Foundation, *Focus on Health Reform: Summary of New Health Reform Law*, <http://www.kff.org/healthreform/upload/8061.pdf> (last visited September 29, 2011).

paid the physician for the service,” rather than the approved Medicare payment amount.⁴³ Even so, these incentives for PCPs represent only temporary solutions.

Reimbursement rates are not entirely controlling of physicians trends in care of Medicaid patients, but often take precedent over other factors.⁴⁴ Compensation is a pillar of maintaining a successful business. A study in 1999 examined changes in the volume of privately insured services in response to reductions in Medicare physician payments.⁴⁵ The primary research question was to determine how significantly, if at all, physicians increased the provisions of privately insured services as a result of Medicare reductions in payment rates for surgical procedures (i.e. shifted their services away from Medicare patients).⁴⁶ Data from 182 hospitals was collected, covering a range of major procedure groups before the reduction in Medicare fees and twenty-one months after the reduction.⁴⁷ Ultimately, the study found that financial considerations influence which patients physicians treat.⁴⁸ Higher Medicaid fees increase probability that a physician will treat Medicaid patients.⁴⁹ Physicians with a significant amount of Medicare and Medicaid patients are usually minimally impacted by reductions in reimbursement due to continuously high volume of patients. However, a physician could be adversely affected if a substantial share of its patients shifted from private coverage to Medicaid, resulting in an overall reduction of reimbursement.⁵⁰ Regardless of the payment rates, the use of physician services as a whole does not significantly fluctuate because program beneficiaries tend to seek needed care in emergency rooms or com-

⁴² Cook, *supra* note 40, at 26.

⁴³ Gunselman, *supra* note 4, at 107.

⁴⁴ Bachrach, *supra* note 5, at 7.

⁴⁵ Thomas Rice, et al., *A Tale of Two Bounties: The Impact of Competing Fees on Physician Behavior*, 24 J. HEALTH POL. POL'Y & L. 1307, 1307 (1999).

⁴⁶ *Id.* at 1314.

⁴⁷ *Id.* at 1307-1308.

⁴⁸ *Id.* at 1326.

⁴⁹ Anne Lenhard Reisinger, David C. Colby & Anne Schwartz, *Medicaid Physician Payment Reform: Using the Medicare Fee Schedule for Medicaid Payments*, 84 AM. J. PUB. L. 553, 554 (1994).

munity clinics, in addition to an office setting.⁵¹

As Medicaid reimbursement rates decrease, practice costs remain the same or higher with the continuing need for information technology and electronic adaptations.⁵² In 2008, Medicare implemented a 10.6% payment cut, which resulted in physicians reducing staff, referring complex cases to specialists and hospitals, discontinuing certain services such as nursing home visits, and even leaving the practice as a whole.⁵³ However, physicians have looked to other areas in the past to make up for these losses, such as cost-shifting and increasing the volume of patients.⁵⁴ Physicians have often cited other administrative reasons for hindrance in participation in Medicaid as well, such as delayed reimbursement and time-consuming billing requirements.⁵⁵ It has been found that reimbursement delays can offset any advantages that states try to achieve by introducing higher fee payments to physicians.⁵⁶

V. QUALITY AS A REIMBURSEMENT FACTOR

The existing issues with low reimbursement rates have resulted in concerns regarding provider participation, quality outcomes and patient satisfaction.⁵⁷ In order to keep their practices financially sound, physicians practice “hamster-wheel medicine”, where visits are kept brief and only focus on acute health problems, instead of prevention and management of chronic conditions.⁵⁸ Chronic disease among the elderly is responsible for greater demands on the healthcare workforce.⁵⁹ Additionally, as the aging

⁵⁰ Zuckerman, *supra* note 35, at 1.

⁵¹ Rice, *supra* note 45, at 1312.

⁵² *Member Connect Survey: Physicians' Reactions to the Medicare Physician Payment Cuts*. AMERICAN MEDICAL ASS'N, DIVISION OF MARKET RESEARCH AND ANALYSIS, http://www.ama-assn.org/ama1/pub/upload/mm/399/mc_survey.pdf (last updated February 2008) [hereinafter *Physicians' Reactions*].

⁵³ *Member Connect Survey*, *supra* note 52.

⁵⁴ Rice, *supra* note 46, at 1328.

⁵⁵ McGinnis, *supra* note 1, at 2.

⁵⁶ Zuckerman, *supra* note 36, at 517.

⁵⁷ Moncrieff, *supra* note 32, at 684.

⁵⁸ McGinnis, *supra* note 1.

⁵⁹ Mullan, *supra* note 6, at 704.

population seeks medical attention from PCPs, many of these patients demand special diagnostic and treatment needs, as well as overall management of care.⁶⁰

Measuring quality can often be difficult due to lack of investment in information technology and research. Additionally, patients are often unaware or uninformed regarding how to assess quality of care, making it difficult to monitor quality and patient satisfaction.⁶¹ To ensure a high measure of quality, the PPACA has added provisions that will track quality outcomes with Medicaid patients.⁶² The Physician Quality Reporting Initiative will become mandatory in 2015, and if physicians fail to report data on their use of quality measures for certain covered services, their payment rates will be reduced by up to two percent per year.⁶³ In addition, value-based modifiers will be implemented in 2015, which will adjust to payment rates under the physician fee schedule, based on how quality compares with costs.⁶⁴ These programs are crucial to incorporating quality into the payment system and measuring overall success in healthcare reform.⁶⁵ However, they will likely prove time-consuming for physicians and their staff as well as costly to implement.⁶⁶

IV. CONCLUSION

It is Congress' hope that the PPACA's projected increase in reimbursement will not only ensure that physicians will see Medicaid patients, but also provide physicians with the time and resources necessary to provide in-

⁶⁰ Mullan, *supra* note 6, at 705.

⁶¹ SEAN NICHOLSON, PH.D., *Will the United States Have a Shortage of Physicians in 10 Years?*, Changes in Health Care Financing & Organization (November 2009), <http://www.academyhealth.org/files/publications/HCFORReportDec09.pdf> (last visited September 30, 2011).

⁶² See Cook, *supra* note 40, at 25.

⁶³ Paul B. Ginsburg, *Rapidly Evolving Physician-Payment Policy – More than the SGR*, 364 N. ENGL. J. MED. 172, 175 (2011) (The Physician Quality Reporting Initiative is a physician-feedback program that allows consumers to report quality based on episodes of care.)

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ Jason Fodeman, *The New Health Law: Bad for Doctors, Awful for Patients*, Galen Institute, http://www.galen.org/fileuploads/NewHealthLaw_BadForDoctors_AwfulForPatients.pdf (last visited September 28, 2011).

creased quality of care. In addition, Congress anticipates that addressing the issue of PCP shortage will improve access to care for Medicaid patients. Approaches for keeping physicians engaged in maintaining Medicaid clients such as improvements in reducing medical school debt and investing in an efficient workforce to support physicians will equate a workload reduction for physicians. It will also allow for flexibility, which will allow for physicians to see a reasonable number of patients while maintaining quality care. Adjusting reimbursement rates, along with providing bonuses, should further advance the goal of incentivizing PCPs to accept Medicaid patients. Finally, measures to ensure quality will also be implemented in the hopes of monitoring the effectiveness of such new programs and provisions. It is likely that if all these programs and initiatives are implemented, the shortage of physicians will be reduced in the upcoming years and new recipients of Medicaid will also be able to secure quality healthcare.