H&HN DAILY

A Coming Physician Shortage for Medicare and Medicaid Patients

By Nathan Kaufman *July 25, 2012*

While the ACA will cover more under government programs, many physicians refuse to accept such patients.

Editor's note: *This is the third installment in "From the Trenches," a new monthly series that continues through October.*

Now that the Supreme Court has affirmed most of the components of the Patient Protection and Affordable Care Act, many believe that the uncertainty is over and we can move on implementation. However, the experience with health care reform in Massachusetts shows that the uncertainty has just begun.

After six years of operating under a reform law similar to the ACA, Massachusetts finds itself wrestling with spiraling health care costs, including Medicaid costs that are now consuming 41 percent of the state budget. According to Jonathan Gruber, an MIT economist who helped craft both the state law and the federal law: "The state has no idea what's driving the growth in health care costs. In fact, it's not even close to figuring it out & . We don't know the answer, we don't know how to fix it now."

In response to these unanticipated, unsustainable health care economics, new emergency legislation has been introduced that would dramatically change health care delivery in the state. In its May 6, 2012, article, "Massachusetts Moves Toward Health-Care Price Controls. Is America Next?" *Forbes* profiled this new law. The 178-page bill, the Health Care Quality Improvement and Cost Reduction Act of 2012, introduces several new concepts to address the unintended crisis resulting from the original health care reform law, including:

- a new, quasi-governmental oversight agency called the Division of Health Care Cost and Quality;
- a cap for health care spending linked to the local economy, the Gross State Product, minus one-half a percent;
- a 10 percent luxury tax on hospitals that charge more than 20 percent of the state median price for a given service unless they can justify that higher price.

Many of the issues that are being addressed by this emergency legislation were predictable when the original law was passed. But rather than anticipate these problems and address them in the original legislation, Massachusetts chose to believe the most optimistic projections and ignore the realities of the market until they have become a crisis.

While the ACA addresses coverage for all (unless a state opts out of the new Medicaid coverage plan), it is likely that the law will accelerate a crisis regarding physician access for Medicaid and Medicare patients. Evidence of this pending crisis is already percolating in the trenches.

Medicare/Medicaid Patients: Good for Business?

Mike Leavitt, former Health & Human Services secretary and leader of Mitt Romney's health care transition team, recently stated that "we have entered into an era of

dispassionate health care, where it's about business and survival & ." This seems to be the consensus of most physicians as well. In a recent survey of physicians reported in *CNN Money* online (June 27, 2012), doctors reported that it is getting much harder for them to earn a decent living, especially in private practice. The reasons given for this increase in financial hardship include: education debt, rising business expenses and administrative hassles, shrinking reimbursement, and costly malpractice insurance.

This cry for help from physicians was articulated in a March 28, 2012, letter from more than 50 physician organizations to Marilyn Tavenner, acting administrator of the Centers for Medicare & Medicaid Services, which stated: "The undersigned organizations are writing to express our profound concern about the imminent storm that is about to occur due to simultaneous implementation of multiple programs that will create extraordinary financial and administrative burden as well as mass confusion for physicians."

The growing disparity between Medicare and Medicaid and commercial rates is a threat to physician income. CMS's Office of the Actuary reports that in 2009, Medicare payments were about 80 percent of private health insurance, while Medicaid payments were 58 percent. However, the gap between government reimbursement and commercial rates is significantly greater for dominant medical groups who are able to negotiate better rates. Given the wide disparity between government and commercial reimbursement, it is not surprising that Jackson Healthcare's Physician Practice Trends Survey 2012 reports that:

- 36 percent of physician respondents reported being unable to accept new Medicaid patients;
- 26 percent of physicians said they do not see Medicaid patients at all;
- 17 percent of all physician respondents reported being unable to accept new Medicare patients;
- 10 percent of physicians said they do not see Medicare patients at all.

This is not news to those of us who negotiate physician transactions for a living. More often than not, physicians begin their negotiations by explaining that they are in "the *business* of practicing medicine." Their implication is that the success of the negotiation and their willingness to engage with the health care system (and open their practice to Medicare and Medicaid patients, take call, etc.) is contingent on first satisfying their concerns about their desired level of compensation in the face of low government reimbursement and new regulatory initiatives.

Numbers That Don't Add Up

A recent discussion with the physician leader of a large, prestigious surgical group in the Southeast about why his group decided to stop seeing new Medicare and Medicaid patients is representative of physician sentiment in the trenches:

First, he pointed out that there is a severe shortage in his specialty, and his group cannot keep up with the demand from the commercially insured population. He explained that the practice overhead for treating Medicaid patients is greater than the reimbursement his group receives from the state (whenever the state has the funds to pay them). With Medicare patients, their conditions are more complex and time-consuming than those of the commercially insured population, and Medicare pays his group about 60 percent less than what they get paid for the equivalent service under commercial insurance.

Had payment rates been his group's only issue, they probably would have kept their practice open to a limited number of Medicare and Medicaid patients. But the complexity and consequences of the new regulations (e.g., the recovery audit contractor and physician quality reporting system programs, etc.) were the tipping point that moved the group to close their practice to new Medicare and Medicaid patients.

The gap between commercial and Medicare reimbursement rates will get even worse if CMS' proposed 2013 fee schedule goes into effect. Most commercial insurance companies are providing physicians with a modest increase of at least 2 to 3 percent. But in exchange for marginal increases in primary care rates (which will have minimal impact on the physicians' after-tax income), CMS is proposing 2 to 4 percent reductions in the fee schedules for radiology, anesthesiology, cardiology, pathology, vascular surgery and urology. In addition, CMS is proposing no increase for allergy/immunology, gastroenterology, general surgery, plastic surgery and rheumatology.

One common theme in every health care system is the demand by local physicians to provide funds to stabilize their incomes at market rates. Given current regulations, it is difficult for health systems to protect the incomes of physicians in private practice from declining reimbursement or to provide direct incentives to independent physicians to see

Medicare and Medicaid patients.

Thus, the health system must use popular physician engagement strategies such as joint ventures, call pay, directorships or co-management agreements. In many cases, these engagement strategies will not provide sufficient cash flow to stabilize a physician's current level of income over the long term. It is also important to note that these engagement strategies usually represent an incremental cost to the health system, e.g., payments for an emergency department call.

Health systems that compensate their employed physicians based on collections minus expense are finding that these physicians are limiting the number of Medicare and Medicaid patients in their practice unless they receive a subsidy for seeing these patients. Most often, this risk of low government rates is mitigated for employed physicians by using a compensation system based on a market rate per wRVU. Under this popular compensation formula, the health system shelters the physician from the unfavorable economics on government-funded programs and absorbs the losses associated with this subsidy.

Unbridled Growth

The primary economic factors that have mitigated physician access problems for Medicare and Medicaid patients are the engagement and employment subsidies provided by health systems. However, the health systems' ability to afford these subsidies over the long term is in doubt. In a recent interview, Medicare's chief actuary, Richard Foster, said that while he's optimistic that providers can improve the quality of care and lower costs, he expressed doubt that the growth rates can be reduced over the long term. In his congressional testimony Foster stated:

"Many ideas have been developed and tried over the years in an effort to reduce health care cost growth. Examples include the development of prospective payment systems and other bundled payment mechanisms; the widespread adoption of managed care plans; efforts to facilitate more prudent use of health care services through consumer-driven health plans and medical savings accounts; use of Lean production techniques by hospitals and other facilities; and, most recently, the development of accountable care organizations, medical homes, disease management and other efforts to better integrate the delivery of care. Most of these efforts have had some positive impact on lowering the level of health care costs, but there is relatively little evidence that they have succeeded in reducing cost growth rates."

Foster also notes that without unprecedented changes in how health care is delivered and payments are made, "the prices paid by Medicare for health services [per the ACA productivity adjustment for hospital inpatient services] are very likely to fall increasingly short of the cost of providing these services." Over time, he projects that payments for some services would be halved, forcing Medicare payments [to hospitals] below Medicaid rates.

As Moody's notes in its June 28 special comment on nonprofit hospitals, the key longer-term, credit-negative effects of the ACA on nonprofit hospitals are as follows:

- Spread over 10 years, Medicare reimbursement payments to hospitals will be reduced by more than $150 billion in addition to $14 billion of Medicaid disproportionate share funding cuts.
- There will be new forms of reimbursement models (such as bundled payments) that also seek to lower reimbursement to hospitals.
- New payment penalties for hospitals with high readmission rates particularly will affect inefficient and poor-quality hospitals.

In addition, regulation of commercial premium increases will have a dramatic effect on a health care system's ability to raise its commercial rates. Clearly, these cuts will impact the ability of health systems to subsidize physicians seeing underfunded government patients.

The Coming Physician Shortage

The Association of American Medical Colleges predicts that by 2025, the supply of physicians will fall 130,600 short of demand. Given the ever-increasing disparity between government and commercial rates, the law of supply and demand suggests that without a subsidy from the health system, physicians will further limit access to Medicare and Medicaid patients. But the ACA will place more pressure on hospital rates, thus threatening the ability of health systems to subsidize physicians for seeing Medicare and Medicaid patients.

Lack of access to physicians for Medicare and Medicaid patients will be one of the first and most predictable unintended consequences emerging from implementation of the ACA. This is a complex problem that requires the immediate attention of the health care policy community today; unfortunately, it is not getting the attention it deserves.

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