AMA
AMERICAN MEDICAL ASSOCIATION

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November 21, 2024

Michael E. Chernew, PhD
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: AMA Comments on November 2024 Meeting–Medicare Physician Payment Update

Dear Dr. Chernew:

On behalf of the physician and medical student members of the American Medical Association (AMA), we commend the Medicare Payment Advisory Commission (MedPAC) for acknowledging the unsustainable trajectory of the current Medicare physician payment system and for exploring ways to increase the default physician payment update to account for increases in the costs to run a medical practice. **We strongly urge MedPAC to recommend that Congress update physician payment on an annual basis by the full increase in inflation as measured by the Medicare Economic Index (MEI) to ensure predictability and stability for physician payment and to maintain or improve access to care.** We also appreciate the opportunity to provide information about the Physician Practice Information (PPI) Survey and urge MedPAC to pause consideration of a recommendation related to maintaining payment accuracy, including revising the 90-day global surgical bundles in light of recently finalized CMS policy changes.

Medicare Physician Payment Update

During the November 2024 meeting, MedPAC expressed concern that growth in the cost to provide physician services, as measured by the MEI, is projected to continue to exceed physician updates, which could negatively affect beneficiary access in the future. The AMA strongly agrees that an inflation-based update to Medicare physician payment is necessary to keep pace with the increased costs of practicing medicine and to preserve access to care. According to the Medicare Trustees, if physician payment does not change, access to Medicare-participating physicians will become a significant issue in the long term. Some Medicare patients are already experiencing inequitable delays in care, and we know that when care is delayed, health outcomes worsen. These problems particularly impact minoritized and marginalized patients[1] and those who live in rural areas.[2]

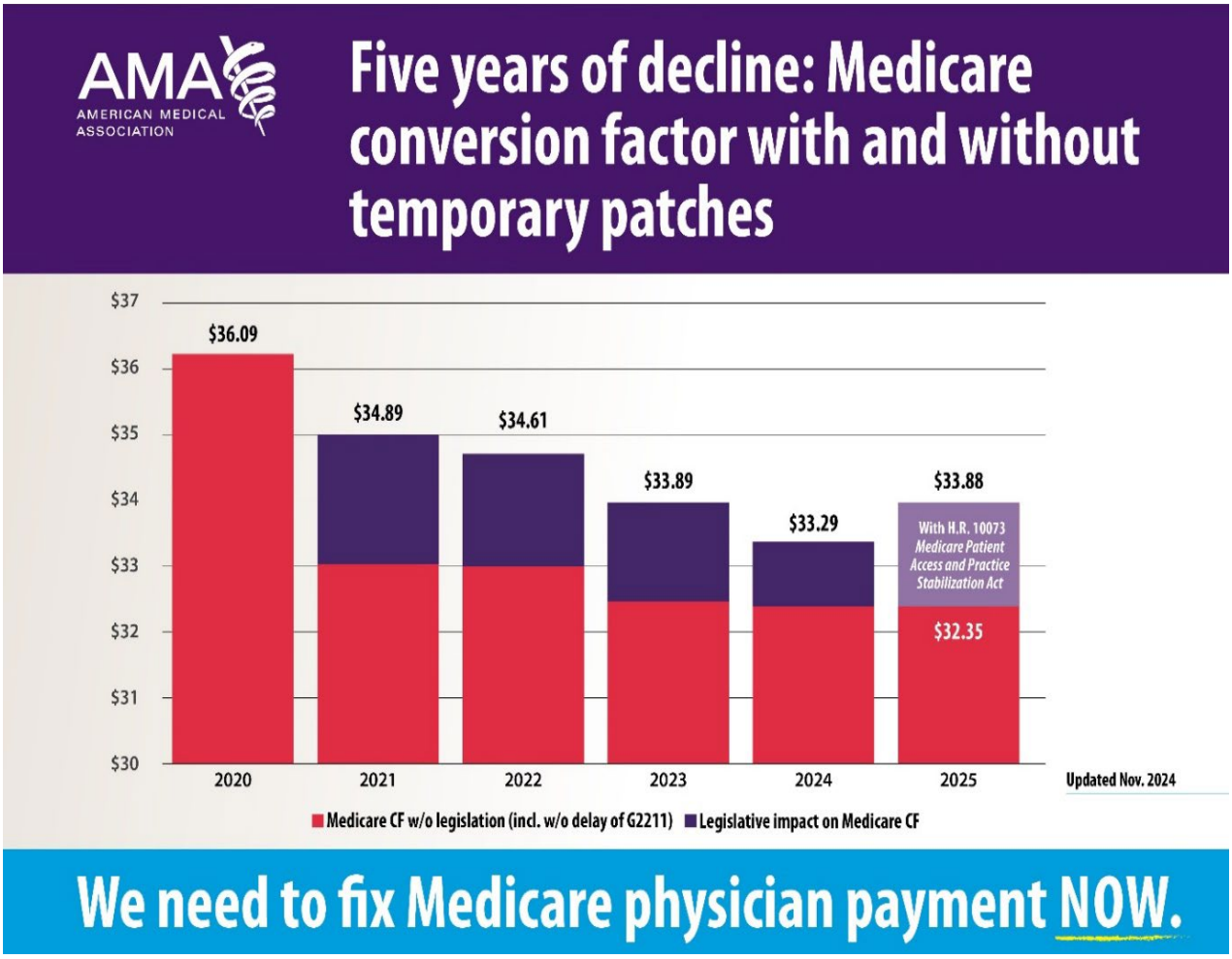
The following findings from MedPAC's own 2024 beneficiary and provider focus groups, presented at the October 2024 meeting, indicate that patients are already experiencing delays, particularly for specialty care and for new patients:

[1] See e.g., Johnston KJ, Hammond G, Meyers DJ, Joynt Maddox KE. Association of Race and Ethnicity and Medicare Program Type With Ambulatory Care Access and Quality Measures. *JAMA.* 2021;326(7):628–636. doi:10.1001/jama.2021.10413.
[2] https://rhrc.umn.edu/wp-content/uploads/2019/12/UMN-Access-to-Specialty-Care_12.4.pdf.

- "In general, beneficiaries reported longer wait times for specialty care than for primary care."
- "Several beneficiaries faced long wait times for specialty care, even when dealing with an acute medical issue."
- "Many beneficiaries reported that wait times as a new patient tended to be much longer than as an established patient."

Unfortunately, physicians again find themselves on the precipice of a pay cut at the start of next year. Specifically, the Centers for Medicare & Medicaid Services (CMS) finalized a 2.83 percent Medicare physician pay cut beginning January 1, 2025, which marks the fifth consecutive year of reductions to Medicare physician payments. At the same time, CMS projects that the MEI will increase by 3.5 percent next year, widening the chasm between what physicians are paid and their practice expenses.

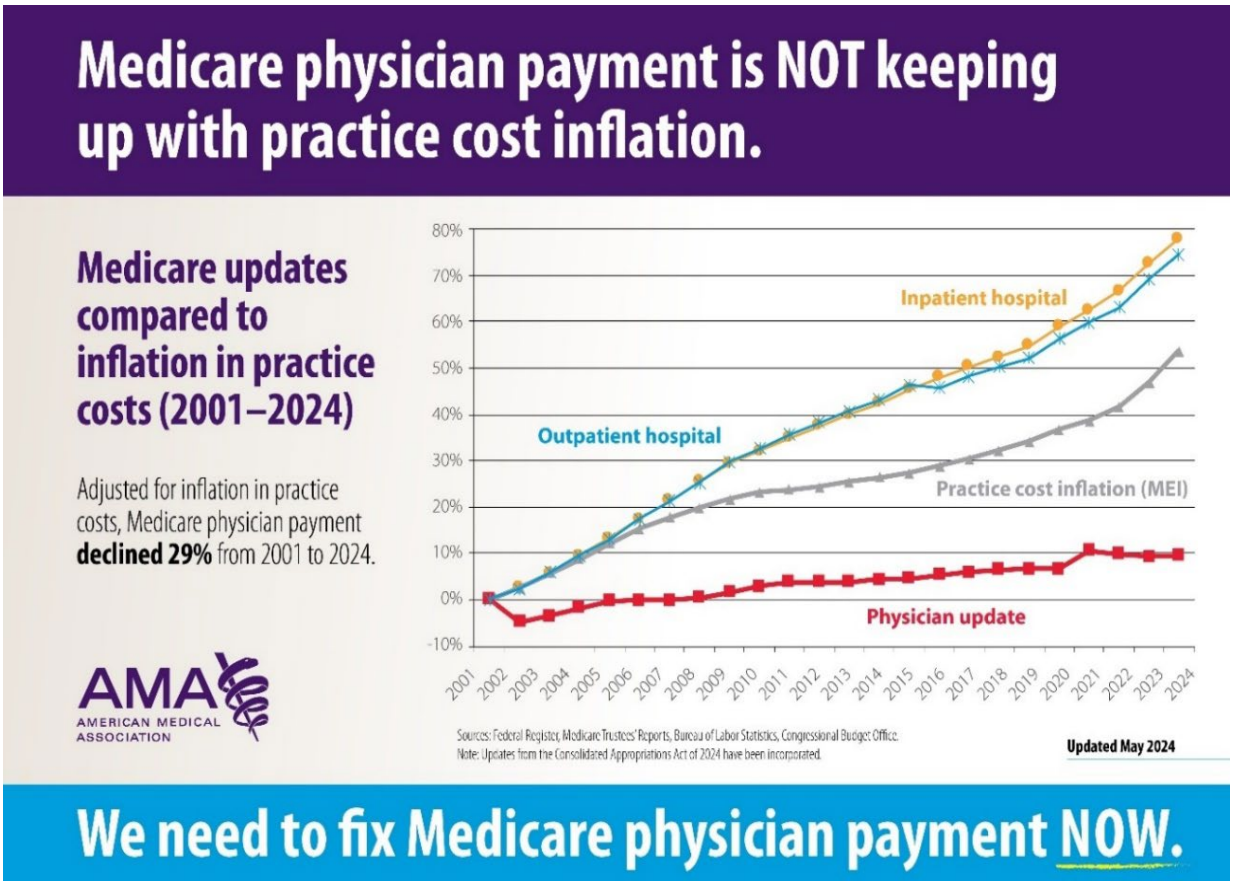
Thankfully, a group of bipartisan lawmakers has introduced a legislative solution to this time-sensitive Medicare payment problem. **The AMA strongly supports H.R. 10073, the Medicare Patient Access and Practice Stabilization Act of 2024.** This bipartisan bill would replace the 2.83 percent cut with a 1.8 percent payment update for 2025, which is equivalent to half of the forecasted MEI increase. The graph below depicts the decline in Medicare physician pay since 2020 and highlights the urgent need for congressional intervention before January 1.



While H.R. 10073 will address the imminent pay cut, long-term reform is necessary to provide stability and predictability in the Medicare Physician Payment Schedule (MPFS). The AMA is pleased that MedPAC is continuing to discuss overdue reforms to the Medicare physician payment system. Specifically, MedPAC discussed replacing the existing differential conversion factor updates of 0.75 percent for qualifying participants in advanced alternative payment models and 0.25 percent updates for all other physicians and qualified health care professionals (QHPs) with a single conversion factor and an annual update tied to the MEI. We deeply appreciate that MedPAC is considering recommending that Congress update physician payments on an annual basis and that Congress make those updates permanent, so they are built into the baseline in future years. This differs from the temporary patches passed by Congress in recent years and displayed in the graphic above. **The AMA is strongly urging Congress to pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, a bipartisan bill with over 170 cosponsors which would establish a permanent Medicare physician payment update by 100 percent of the MEI.** Such an update would allow physicians to keep pace with rising practice costs so they can continue to invest in their practices and implement innovative strategies to provide high-value, patient-centered care.

The AMA remains concerned about MedPAC's consideration of an update that is less than the increase in the cost to practice medicine as measured by the MEI. One potential misperception raised at the November 2024 meeting that may be leading to this recommendation is that the MEI does not account for improvements in productivity over time, which is untrue. As CMS stated in the 2023 MPFS final rule, "[t]he MEI is a fixed-weight input price index comprised of two broad categories: (1) Physicians' own time (compensation); and (2) physicians' practice expense (PE). Additionally, it includes an adjustment for the change in economy-wide, private nonfarm business total factor productivity (previously referred to as multifactor productivity)." The Final Report from the Medicare Economic Index Technical Advisory Panel includes a detailed discussion about the use of an economy-wide productivity adjustment in the MEI.

Furthermore, we firmly disagree that MedPAC should rely on historical evidence that a full MEI update is not necessary to maintain access to care. As several commissioners pointed out in the discussion, if we wait until there is clear evidence of lack of access to care for Medicare beneficiaries, it will be too late to reverse the complex market and economic trends driving those trends. For example, MedPAC remains concerned about the site-of-service payment differential, which is an incentive for vertical consolidation. As you can see from the chart below, payment updates to hospitals remain significantly higher than payments to physicians and are even higher than MEI growth. Between 2001 and 2024, Medicare hospital updates totaled over 70 percent (78 percent for inpatient services and 75 percent for outpatient services), with average annual increases of 2.5 percent for both inpatient and outpatient services. In comparison, Medicare physician pay has increased just nine percent over the last 23 years, or 0.4 percent per year on average. That nine percent includes the temporary 2.93 percent update that expires at the end of this year.



Just as updating physician payment by only a portion of MEI will still allow the gap between the growth in the medical practice costs and physician payment to continue to cumulate and grow over time, it will allow the gap between hospital payment and physician payment to cumulate and grow over time, thus preserving existing forces for vertical consolidation. In addition, there are significantly greater administrative demands on physician practices today than in the past 20 years, such as the average $12,800 cost per physician per year to participate in the Merit-based Incentive Payment System.

These changes challenge the idea that MedPAC should rely on the past as it considers Medicare physician payment updates for the future. **The AMA strongly urges MedPAC to recommend an annual physician payment update by the full increase in inflation as measured by the MEI, which includes a productivity adjustment, to ensure predictability and stability for physician payment and to maintain or improve access to care.**

Improving Payment Accuracy

As mentioned during the November 2024 meeting, in response to a need for more up-to-date data pertaining to practice costs, the AMA launched the 2023/2024 Physician Practice Information (PPI) Survey, which closed on August 31, 2024, to collect detailed information on physician and other health care professional compensation, practice costs, and direct patient care hours worked. The survey represented a significant undertaking supported by more than 170 national medical specialty societies, health care professional organizations, and all state medical societies. The AMA is collaborating with Mathematica, an independent research company with extensive experience in survey methods as well as care delivery and finance reform, to analyze the data and plans to share information with CMS. A

coalition of QHP organizations also worked with Mathematica to administer a similar survey. CMS will continue to delay implementation of the 2017-based MEI cost weights, pending the PPI Survey. The AMA has previously briefed MedPAC staff on this survey and would be happy to meet again.

We wish to address comments at the November meeting about the previous PPI Survey leading to payment reductions to cardiologists that, from one commissioner's perspective, had caused the shift from independent practice to employment among cardiologists. This statement paints an incomplete depiction of other policy changes that negatively affected cardiologists' ability to maintain an independent practice. Most significantly, the Deficit Reduction Act of 2005 (DRA) lowered Medicare payment for certain imaging services under the MPFS so they would not exceed what Medicare pays for those services under the Hospital Outpatient Prospective Payment System (OPPS)—known as the OPPS cap. CMS implemented the OPPS cap on January 1, 2007.

According to a U.S. Government Accountability Office (GAO) study, "the OPPS cap reduced the fee for the performance of about one in four physician imaging tests overall, and fees for advanced tests were more likely than other imaging tests to be paid at the OPPS rate… For example, among the three most commonly performed MRIs subject to the cap, fee reductions ranged from about 21 to 40 percent." The GAO concludes, "our analysis shows that the implementation of the OPPS cap was the factor that had the greatest impact on the change in Medicare physician imaging expenditures, which declined 12.7 percent in the aggregate in 2007. Specifically, we estimate that in 2007 the implementation of the OPPS cap caused spending on physician imaging services to decline 11.1 percent. In addition, a decrease in the size of Medicare's FFS population caused 2.5 percent decline in expenditures, and a change in PFS fees for imaging services caused an additional 3.6 percent decline." Similarly, in an article published in JAMA Cardiology, the authors delineate the passage of the DRA as the point in time in which payment for echo and nuclear imaging in the office setting began to decline.

Furthermore, the PPI survey is intended to collect information to utilize in a payment system based on relative costs between physician specialties and other health care professionals. Prior to implementation of the last PPI survey in 2007/2008, cardiology conducted, and CMS accepted, its own supplemental survey which temporarily increased PE relative value units for cardiologists relative to other specialists and QHPs. The 2007/2008 PPI survey then restored the relativity of cardiology to what it had been prior to the supplemental survey.

Turning to the global surgical codes, given recent changes in CMS policy, MedPAC should pause any recommendations related to global surgical services to allow time to monitor the utilization and impact of recently finalized coding and payment changes, including any unintended consequences, particularly with respect to access to high-quality, post-operative care. Specifically, CMS finalized for 2025 an expanded requirement to use modifier -54 when a physician plans to furnish only the surgical procedure portion of a 90-day global package, including when there is a formal, documented transfer of care as under current CMS policy or an informal, non-documented but expected transfer of care. CMS also finalized coding and payment for an office visit add-on code (G0559) to capture the additional time and resources spent providing post-operative care by a physician who did not perform the surgical procedure and who has not been involved in a formal transfer of care agreement.

The AMA strongly agrees with several Commissioners who emphasized the complexity of and potential for adverse consequences when it comes to a recommendation to improve relative "payment accuracy" within the MPFS, and the need to prioritize the recommendation for an MEI-based payment update.

The AMA appreciates MedPAC's attention to opportunities to correct the current deficiencies of the current Medicare physician payment system and thanks the Commission for its consideration of our input on these topics. If you have any questions regarding this letter, please contact Jennifer Hananoki, Assistant Director, Federal Affairs, at jennifer.hananoki@ama-assn.org.

Sincerely,

James L. Madara, MD