AMA
AMERICAN MEDICAL ASSOCIATION

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December 20, 2024

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

Re: AMA Comments on December 2024 Meeting – Medicare Physician Payment Adequacy

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 stressing for the third straight year that physician payment rate updates should be based on an inflation-based index for Medicare. The AMA could not agree more that the 0.25 percent and 0.75 percent updates, depending on qualifying alternative payment model participant status, under current law for 2026 are inadequate and far below the cost to provide care to America's seniors and people with disabilities. We urge MedPAC to recommend a physician payment update that keeps pace with the rate of inflation. Additionally, we write to explain the role of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) in increasing payment for primary care physicians and to clarify that the Medicare Economic Index (MEI) includes a productivity adjustment.

1. Increasing Physician Payment by the Full MEI

The AMA applauds MedPAC for again acknowledging during their December 2024 meeting the widening gap between what Medicare pays and physicians' practice expenses and for stressing for the third straight year that physician payment rate updates should be based on an inflation-based index for Medicare. The coming year will mark the fifth consecutive year of Medicare cuts, and physicians' Medicare reimbursement is down 29 percent since 2001 when adjusted for inflation in practice costs. Physicians are being paid nearly 30 percent less for the same work they did two decades ago, while costs to provide care and run an office have soared.

Specifically, MedPAC is considering recommending that Congress update physician payment by MEI minus one percentage point in 2026. This would be a permanent one-year update that would replace the inadequate current law updates. While we agree that this recommendation is a significant improvement compared to current law, we continue to believe that updates below the rate of inflation in practice costs will allow the cumulative gap between what Medicare pays and what it costs to provide care to continue to widen. This will threaten physicians' ability to cover rising practice costs including staff salaries, rent, and medical supplies. 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. The Trustees also point out that the expiration of the $500 million in Merit-based Incentive Payment System (MIPS)

bonuses in 2025 and the decline in Advanced Alternative Payment Model (APM) incentives will result in further payment reductions for most physicians. **Therefore, we strongly urge MedPAC to recommend that Congress update Medicare physician payment by the full increase in MEI in 2026.**

Finally, the AMA also appreciates that MedPAC has expanded its annual access-to-care survey to add questions about the length of beneficiaries' wait times to see physicians. We agree with the commissioner who requested that MedPAC use a more congruent comparison group when evaluating Medicare beneficiaries' access to care, such as patients with commercial insurance who are 62-67 years old. The comparison between a 55-year-old on private insurance and a 75-year-old on Medicare is not apples-to-apples. As another commissioner pointed out, a 75-year-old Medicare beneficiary should not have to wait weeks to see a new physician after being discharged from the hospital or when facing a new diagnosis. We encourage MedPAC to make these refinements and continue to include these questions in its annual survey of beneficiaries.

2. RUC's Efforts in Support of Increasing Payment for Primary Care Services

During the December meeting, one commissioner expressed concern about the RUC's effectiveness in improving payment for primary care services. We wish to correct the record and highlight several notable RUC actions in support of increased payment for primary care physicians and qualified health care professionals. We welcome the opportunity to meet with commissioners to discuss the work of the RUC broadly or specific to primary care services in greater detail. The AMA also extends a standing invitation to all commissioners to attend a RUC meeting.

In 2021, the Centers for Medicare & Medicaid Services (CMS) implemented the revised office and outpatient evaluation and management (E/M) codes for new and established patient offices visits. As part of the revision, the RUC recommended increased valuation for E/M codes, which CMS implemented, resulting in a $5 billion redistribution from other services to office and outpatient visits. Since the inception of the resource-based relative value scale (RBRVS), Medicare payment for a mid-level office visit (CPT code 99213) has increased from $31 in 1992 to $91 in 2024. In comparison, payments for cataract surgery (CPT code 66984) have decreased from $941 to $537 and payments for MRI of the lumbar spine (CPT code 72148) have decreased from $485 to $196.

As a result of years of advocacy by the RUC and the AMA to ensure that the resource-costs required to provide immunizations are recognized, CMS increased payment for immunization administration (CPT code 90471) from less than $4 in 2002 to $21 in 2024. CMS also adopted the data from the AMA-led Physician Practice Information (PPI) Survey in 2010, establishing standardization and redistribution to primary care services. The combined practice expense and professional liability insurance relative value units for a mid-level office visit for an established patient (CPT code 99213) are 340% of the values established at the inception of the RBRVS.

In 2006, the RUC established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. Since the inception of the Relativity Assessment Workgroup, the Workgroup and CMS have identified over 2,800 services through over 20 different screening criteria for further review by the RUC, which account for approximately 95 percent of the Medicare Physician Fee Schedule (MPFS) allowed charges. Codes that have not been reviewed are low volume and represent a minimal amount of allowed charges. The RUC via its potentially misvalued services review has recommended reductions and deletions to over 1,600 services, resulting in the redistribution by CMS of $5 billion annually.

Finally, since the RBRVS was implemented in 1992, payment for primary care specialists increased as a share of total MPFS total allowed charges. Specifically, primary care specialists' charges increased from 23 percent to 29 percent in 2023. By contrast, surgical specialties' share significantly declined from 30 percent to 18 percent of allowed charges in 2023. Similarly, the share for other specialties (e.g., radiology and anesthesiology) decreased from 25 percent to 22 percent of allowed charges in 2023. **The RUC has a successful track record of work in support of increasing the value of new and existing primary care and preventive care services.**

3. MEI Includes a Productivity Adjustment

At the December 2024 meeting, we continued to hear confusion about whether the MEI includes a productivity adjustment, and we are concerned that the confusion may be leading to potentially misguided support for a recommendation to reduce MEI by a certain amount to ensure that productivity is captured when in fact it already is. There is reasonable cause for confusion as many Medicare providers' inflation indices and market baskets do not include a productivity adjustment. However, we wish to be clear that the MEI is unique and does account for economy-wide productivity. In the 2023 MPFS final rule, CMS provided, "[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. We urge MedPAC not to reduce its annual physician payment update recommendation to account for a productivity adjustment as a productivity adjustment is already built into the MEI.

Conclusion

The AMA appreciates MedPAC's recognition of the inadequacy of current law updates to Medicare physician payment and thanks the Commission for its consideration of our input on this topic. 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