AMA
AMERICAN MEDICAL ASSOCIATION

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

Re: AMA Comments on March 2025 Meeting

Dear Dr. Chernew:

On behalf of the physician and medical student members of the American Medical Association (AMA), we applaud 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 the increase 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 weigh in on the draft recommendation to improve the accuracy of relative payment rates, share an update about the Physician Practice Information (PPI) survey, and provide information about the AMA/Specialty Society RVS Update Committee (RUC). Finally, the AMA offers support for recommendations for a more robust regulatory structure for Institutionalize Special Needs Plans (I-SNPs).

Medicare Physician Payment Update

During the March 2025 meeting, MedPAC continued to express concern that the growth in the cost of providing physician services, as measured by the MEI, is projected to exceed physician updates, which could negatively affect beneficiary access to care 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]

MedPAC's 2024 access-to-care survey found that 28 percent of Medicare beneficiaries waited six weeks

[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.

or longer for an appointment with a new primary care physician. Similarly, 29 percent of Medicare beneficiaries waited six weeks or longer for an appointment with a new specialist. As Commissioner Miller pointed out at the December 2024 meeting, 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. In addition, we could not agree more with comments made by several commissioners that access indicators are starting to show cracks in the system. If Congress waits until there is worsening evidence of lack of access to care for Medicare beneficiaries, it will be too late to reverse the complex market and economic drivers of those trends.

Unfortunately, physicians are absorbing a pay cut of 2.83 percent in 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 this year, widening the chasm between what physicians are paid and their practice expenses. In fact, when adjusted for inflation in practice costs, Medicare physician pay declined 33 percent from 2001 to 2025, or by 1.7 percent per year on average. Under current law, beginning January 1, 2026, physicians will see a measly 0.25 percent update unless they participate in an advanced alternative payment model, in which case their update will be a slightly higher 0.75 percent. These updates will fall far short of the input costs of physician services, which threaten to continue the instability in the Medicare Physician Fee Schedule (MPFS).

The current trajectory is unsustainable and risks worsening patient access to care, and MedPAC's consideration of overdue reforms to the MPFS is well-timed. Specifically, MedPAC discussed recommending replacing the differential conversion factor updates with a single conversion factor tied to a portion of MEI (such as MEI minus one percentage point). We deeply appreciate that MedPAC is considering recommending that Congress replace the differential conversion factors with a single conversion factor and update physician payments on an annual basis. We applaud the Commission for identifying the importance of making 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.

We remain concerned, however, about MedPAC's consideration of an update that is less than the increase in the cost to practice medicine as measured by the MEI. We continue to disagree that MedPAC should rely on historical evidence that a full MEI update is not necessary to maintain access to care. For example, MedPAC remains concerned about the site-of-service payment differential, which is an incentive for vertical consolidation. 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.**

If the Commission does move forward with a recommendation of tying physician payment updates to a portion of MEI, we strongly urge MedPAC to add a floor of at least 50 percent of MEI. If MEI were to drop to close to one percent, physicians could see a miniscule update or even a negative update.

Physician payment updates, like payment updates for other Medicare providers, should track inflation minus productivity, as MEI does.

Accuracy of MPFS' Relative Payment Rates

We agree with the Commission that the timeliness and accuracy of data informing practice costs is essential. Since our most recent letter to MedPAC, the AMA concluded our analysis of the 2023/2024 PPI survey and submitted the results and methodology to the Centers for Medicare & Medicaid Services (CMS) for consideration in its exploration of changes to the practice expense component of the MPFS or MEI cost weights in future rulemaking. 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 collaborated with Mathematica to analyze the data, and a coalition of qualified health care professional organizations also worked with Mathematica to administer a similar survey. The AMA has previously briefed MedPAC staff on this survey and would be happy to meet again to discuss the results.

The AMA urges MedPAC to reconsider its proposal to reduce indirect practice expense when a service is performed in a facility setting, such as a hospital outpatient department or ambulatory surgery center (ASC), as this would hurt private practice physicians who provide services in the facility setting and could have the unintended consequence of further incentivizing consolidation. The results from the 2024 PPI survey data showed $57 in indirect expenses per hour of direct patient care for hospital-based medicine and $62 for hospital-based surgery. These are not facility expenses. Respondents were instructed to only include costs related to the physician practice, such as coding and billing.

When a private practice physician performs a service or procedure in the facility setting, their physician practice still has to handle coding and billing for the physician claim and scheduling as well. Physician practices would still have administrative staff, and their clinical staff often perform some work supporting services that are performed in the facility. These administrative and clinical staff who are employed by the physician practice often need their own office space (separate from the hospital/ASC), require Information Technology expenses and be supported by other general staff (e.g., human resources, legal). There may also be a practice manager and, for very large practices, an executive team.

Also, CMS includes direct PE inputs (e.g., clinical staff, supplies and/or equipment) in the facility relative value units (RVUs) for 5,143 Current Procedural Terminology (CPT) codes. These direct costs for facility services coincide with indirect costs as well that are incurred by the physician practice. For surgical global codes performed in the facility setting, the bundled post-operative office visits are often performed in a physician office even though the major surgery was performed in the facility setting; this nuance would not show up in the claims data.

Finally, we appreciate that MedPAC does not mention global surgical services in its Draft Recommendation 2. As we stated in our November 2024 letter to MedPAC, CMS recently finalized changes to global surgical services and MedPAC should allow time to monitor the utilization and impact of recently finalized coding and payment changes, as well as any unintended consequences 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.

AMA/Specialty Society RVS Update Committee

We understand that MedPAC plans to include a discussion of the RUC along with its recommendations, and we offer a few key details about the RUC to assist as you consider this aspect of the report. First, the RUC is a body of volunteer physicians and other health care professionals that provides the federal government with recommendations on the resources required to deliver health care services and procedures, incorporating the input of hundreds of experts from all corners of medicine. CMS is entirely responsible for the resource-based relative value scale (RBRVS), and all modifications are made through rulemaking and are open to public comment. For example, most relevant to the discussion at the March 2025 meeting, the RUC reviews the direct practice expense inputs for services and submits recommendations on clinical staff (type and time), medical supplies (type and number of units), and medical equipment (type) involved in providing services. The RUC does not recommend practice expense RVUs and is not even able to replicate the CMS practice expense RVUs. CMS developed the practice expense methodology, and CMS prices wages, supplies, and equipment. Additionally, several of the RUC's recommendations to improve the practice expense methodology have not yet been fully adopted.

Second, the RUC ensures an accurate, transparent, and efficient process for streamlined patient care. Every year, the RUC holds three meetings to review CPT codes that are either new, revised or considered potentially misvalued by either CMS or the RUC's own process of identification performed by the Relativity Assessment Workgroup. Meetings are open to all interested parties, and several MedPAC staff members attended the September 2024 RUC meeting. The AMA maintains an open invitation to Commissioners to attend a RUC meeting, including the April 23-26 and September 24-27 meetings in Chicago, IL. All details of each meeting are public record and accessible online. Individual RUC members exercise their independent judgment and are not advocates for their specialty. The RUC has a strict conflict of interest policy and does not allow undue influences of industry in the process. The RUC looks to each specialty society to provide accurate time and survey data. An attestation statement of accuracy and potential conflict of interest is required of each advisor presenting to the RUC.

Third, the RUC utilizes a breadth of clinical expertise to ensure patients have the best care possible. The expert committee is comprised of 32 members, nine of whom are primary care physicians, with 300 physician and other health care professional advisors. Of the 29 voting members, 21 are from specialties whose Medicare allowed charges are primarily derived from the provision of evaluation and management (E/M) services, such as office visits and visits bundled into 010-day and 090-day global period services. The RUC has recommended significant increases to E/M services, as recently as 2021 and 2023, and the work RVU for an established patient office visit requiring low-level medical decision-making and typically lasting 20-29 minutes, has increased 124 percent since the inception of the RBRVS. Furthermore, the RUC is inclusive of all health care professionals. Non-physicians/doctors of osteopathic medicine who have a Medicare benefit (e.g., nursing, podiatry, physical therapy) have an advisory committee, one voting seat on the RUC, and participate on RUC Subcommittees. An audiologist and a nurse practitioner currently represent these health professionals in the voting Health Care Professionals Advisory Committee seat on the RUC.

Finally, and importantly, the RUC uses a meticulous process to enable innovation in prevention and treatment for patients. As actively practicing physicians, RUC members ensure that innovation in care models is properly accounted for and can be implemented into practice. While the RUC is not required to submit recommendations and CMS is not obliged to accept them, it is crucial for the federal government

to consider input from the doctors and front-line medical health professionals about the medical services they perform in their daily patient care. The input of the RUC also helps ensure that the government adopt policies that reflect current medical practice. The result of this process is a balanced system in which physicians volunteer their highly technical, and unique firsthand expertise regarding complex medical procedures while the government retains oversight and final decision-making authority.

Institutional Special Needs Plans

We want to commend MedPAC for its exploration of I-SNPs and institutionalized care. We appreciate the commission's interest in additional areas for potential future study relevant to I-SNPs.

As the materials noted, the number of provider-owned plans, particularly those operated by nursing homes, has expanded rapidly in recent years. Larger, for-profit facilities are more likely to participate in and have their own I-SNPs. This can present a potential conflict of interest because the plan, acting as an insurer, may be incentivized to deny coverage for necessary care. It is important to have appropriate patient safety metrics specific to I-SNPs in place to ensure patients are getting the care they need.

The commissioners also acknowledged the relatively common lack of coordination between the I-SNP's independent nurse practitioner (NP) with a patient's regular care providers, facility staff, and medical directors. We share this concern. Maintaining care relationships with the providers and facility staff responsible for overseeing their care is critical to coordinating services and maintaining patients' overall health, which leads to better health outcomes, particularly for complex and frail patients. Should I-SNPs engage their own NPs, it is critically important that a collaborative practice agreement be in place preemptively between that NP and the patient's regular physicians and facility staff responsible for overseeing their care to ensure clinical and billing expectations and requirements are mutually understood and levels of care are appropriately maintained and coordinated amongst all parties.

The AMA appreciates the Commissioners calling attention to the lack of regulatory framework specifically geared towards I-SNPs. Currently, I-SNPs are largely regulated by general Medicare Advantage provisions, which have several limitations in applicability to I-SNPs. Importantly, this lack of regulation also extends to a lack of quality measurement and oversight specific to I-SNPs. We agree with the commission that a more robust regulatory framework for I-SNPs, including targeted quality measures, is needed.

As the commission explores work in this area, the AMA strongly supports recommendations for a more robust regulatory structure for I-SNPs, including enhanced oversight as well as targeted quality and patient safety measures. This measure and oversight framework should protect against denied coverage for medically indicated services, and coordination between an I-SNP NP with an enrollee's lead physician and facility staff, which is crucial to ensuring continuity of care and superior outcomes.

I-SNP enrollees represent some of America's most vulnerable elderly patients. As I-SNPs grow in popularity, it is important to ensure there is an appropriately robust regulatory framework in place to guarantee that care decisions are being made with patient continuity of care and safety in mind.

Conclusion

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