Medicare physician fee schedule & Dobbs decision with Todd Askew

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Featured topic and speakers

In today’s episode of Moving Medicine, AMA Senior Vice President of Advocacy Todd Askew discusses the latest advocacy efforts on Medicare physician payment reform and protecting patients’ reproductive rights with AMA Chief Experience Officer Todd Unger.

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Speaker

- Todd Askew, senior vice president, advocacy, AMA

Transcript

Unger: Hello, this is the American Medical Association's Moving Medicine video and podcast. Today we have an update on advocacy issues important to physicians, including Medicare payment reform and a reaction to the Dobbs decision. This episode is brought to you as part of our ongoing work on the AMA Recovery Plan for America's Physicians.
I'm joined today by Todd Askew, the AMA senior vice president of advocacy in Washington, D.C. And I'm Todd Unger, AMA's chief experience officer in Chicago. Todd, it's great to have you back. The AMA advocacy team has been extremely busy lately.

And I know a huge priority is reforming Medicare payment and protecting physicians from future pay cuts. CMS recently released its proposed 2023 Medicare physician payment schedule. And there are some big concerns there. Why don't we start by taking us through what those look like?

**Askew:** Well, thanks, Todd. I'm glad to be back. And first of all, I mean, there are some good things in here. There's a significant expansion of behavioral health services and cancer screening. But as you mentioned, there are some significant concerns not all of which were unexpected.

We're in the process of analyzing what is a 2,000-plus page regulation. But there are some things that are pretty clear right off the bat. And the main one is that it just does not, and by statute really cannot, take into effect some of the harsh economic realities that are higher medical inflation costs and then the continuing COVID-19 concerns. And part of this is played out in some pretty damaging, across the board, payment reductions, which is something we are obviously very concerned about and are going to be working with Congress to prevent.

**Unger:** Can you just clarify for the audience out there, Todd, you said, by statute, it can't do that. What do you mean by that?

**Askew:** Sure. So, the formula is locked in. Parts of it, not every proposal is locked in. But the two main things that are causing a 4.5% reduction in the conversion factor are the expiration of the 3% kind of add-on payment that was included last year. And it was 3.75% the year before, which was there to offset some previous adjustments they had made. That expires this year. We're hopeful to get that extended.

And then additional budget neutrality changes brought about by some changes to E&M codes in the inpatient setting mainly. That's and a percent and a half. So overall, we're looking at a conversion factor reduction of about 4.5%.

**Unger:** Those are big numbers too. And of course, if you're reading the papers, you know, we're also in an inflationary period. How is that addressed in this?

**Askew:** So, unfortunately, it's not. The statute as part of the legacy of the—getting rid of the SGR says for a period here, the update to physician payments is 0.

There's a small update built in the future, not nearly enough to keep up with the cost of inflation.
Physician Medicare fee schedule is really the only fee schedule in all of Medicare, of all types of Medicare providers, hospitals, hospice, home health, et cetera, that does not have some sort of adjustment to keep up with the cost of inflation. And that's what we're seeing played out here. It is not responsive to the real-time economic situations that physicians are facing.

**Unger:** Those are a lot of reductions. When you translate into what that means for physicians and patients, how does that look?

**Askew:** Well, it means a continuing deterioration of the ability of physicians to care for Medicare beneficiaries in the way they should be cared for. It's essentially been over 20 years since there's been any real increase in payments under the Medicare physician fee schedule. We spent much of that time fighting off reductions. And successfully, to an extent.

But over time, obviously, the lack of inflationary increases is in and of itself a reduction. And so, the real fact of the matter is that practices, especially those heavily reliant on Medicare revenue, smaller practices, rural practices, those that see a lot of seniors, they're not able to keep up with the cost of providing that care.

It's resulted in a lot of changes in the health care system, consolidation, a lot of physicians becoming employed, both of which are fine choices if it's a choice that a physician makes because that's how they would prefer to practice or how they can better serve their patients.

But it shouldn't be a choice that is forced upon physicians by financial circumstances which should be addressed by Congress and the administration. That is, at least keeping payments in a place where we can keep up with the cost of inflation.

**Unger:** So, the combination of a lot of these cuts does threaten patient access. Can you talk a little bit about what does that mean when we say that?

**Askew:** Well, it's keeping the doors open. I mean, obviously, physicians are seeing increases in the cost of employing staff. There's a nationwide shortage of employees and a lot of industries. Health care is not exempt. Especially health care, I would say because we've seen a lot of people leaving the field, a lot of nurses especially, leaving nursing, for example in this kind of back half, backside, hopefully, of the pandemic and everything people have been through.

But it's not just because of that. We see inflationary pressures on wages across the board. And if you can't pay your staff, if you can't keep up with rent payments or utility payments. If the dollars coming in don't keep up with the increases in those areas, you can't even keep your doors open. And if you can't keep your doors open, that means a lot of patients going to have to look elsewhere for care.
Unger: The AMA Recovery Plan for America’s Physicians is really rooted in this idea of, we’ve been through 2 and a half years at this point of the pandemic where physicians have been taking care of this nation. And we’re looking to really renew that commitment back to physicians.

I think what I hear you saying is there are statutory things here at play that put us in this position every year, it seems, of having to fend off cuts like this. How do you advocate now to prevent these cuts in the short and the long term?

Askew: Sure. Well, there's really two factors here, especially when it comes to Medicare. One, we've been discussing here the fact that Medicare payments don't keep up with the cost of providing care. And that absolutely must be addressed. That's number one.

The second thing is just the burden, the stress, the hoops you have to jump through just to care for these patients. And that's rooted in the structure of the Medicare payment system itself. When we had, we're able to eliminate the SGR. We got MACRA in replacement.

And it fended off a significant cut across the board in Medicare. But what it gave us in exchange was this series of legacy programs that kind of cobbled together quality reporting, alternative payments, different options for physicians. It was aspirational in how it was put together. And unfortunately, those pieces just haven't worked very well together. And they've created quite a burdensome situation for physicians who are practicing the Medicare.

Quality reporting requirements that seem unrelated to the care that's being provided, that aren't very clear where, how this—if I check this box or report this information, how is that actually improving the care I'm providing to my patient? The data that physicians get on how they're doing is two years delayed. The incentive payments that they may get for performing at an exceptionally high level don't come till down the road. They're really disconnected from the care that's being provided.

Also, there was the promise of alternative payment models, a new way physicians can practice, where they can focus on particular models of care that are patient-centered, that fit their practice, that fit their patient population. It gives them an alternative to a lot of these reporting requirements.

But unfortunately, those never materialized despite a lot of work done by physicians, the AMA, medical societies, both state medical associations and specialty medical associations working to put forward ideas for payment models. They were never implemented by CMS. And so we're left with this very complicated, very disjointed program that seems to lack a lot of relevance and alignment.

And then also, lack of predictability for physicians to know what's coming down the road. What is the next payment cut going to be? Whether I'm going to make—qualify for that bonus. And so, it's a very difficult situation.
Unger: Well, I guess that is why reforming Medicare payment is such a key part of the recovery plan for America’s physicians. As part of that, you recently worked with state, medical and national specialty societies to develop a set of principles to guide advocacy efforts on Medicare payment reform. Tell us about those principles and why they’re so important.

Askew: Right. And it's beyond payment. It's about how the system works to better serve the needs of patients and to make more sense and better meet physicians where they are. Focus on a couple of principles, several key principles—simplicity, relevance, alignment across practices and patient populations and predictability, which I mentioned earlier.

It’s really, what would a rational Medicare payment system look like? And we work very closely with state medical associations, national medical specialties and came together on a series of principles focused on those principles. Some kind of put the meat on the bones of those ideas, if you will, and have over 120 medical associations who have signed on to this. And this is what we are taking to Capitol Hill.

Number one of those principles is a positive inflationary-based update. And secondly, which is related, modifying or replacing or revising the way budget neutrality payment or budget neutrality adjustments are applied in the physician practice area so that we are not constantly having dollars literally taken out of the payment system and not coming back in elsewhere. They literally just evaporate, which really compounds the problem of not having any sort of inflationary update.

We also need to do a better job of recognizing physician practices that are engaged in really exceptionally high-value care and the savings that are associated with that to the Medicare system as a whole. Right now, these payment models and efforts by physicians to keep their patients healthy, there’s not a lot of opportunity for practices to share in any of the benefit that they bring to the system by keeping those patients healthier.

And we also really want to encourage collaboration and competition and innovation across physician practices, rather than having people just throw up their hands and say, I need to become employed. Or I need to give up this type of practice.

We need to make sure that not just the large, really advanced practices that may have the capital and the technology and the staff to participate in really advanced models of care. We want to make sure that even the small practice that may not have access to that capital or other resources are able to participate in alternative models of care and payment that benefit their patient but also benefits the practice and Medicare as a whole.

So those are just a couple of the direction that we’ve been talking to other physician organizations about. And taking that to Capitol Hill and offering this vision so that we can set aside this annual battle once again of just trying to prevent cuts, trying to keep the system from collapsing, trying to keep
physicians from having to walk away, and instead offer a picture, a vision, if you will, of what a new, modern, Medicare system focused on patients, focused on sustainability, focuses on innovation and the benefits that all that brings to the Medicare system.

**Unger:** Well, there's obviously a lot to learn. And it's critical that physicians understand what they're facing. Where can physicians take a deeper dive into these recommendations and learn more?

**Askew:** Well, we are going to be discussing it more—there's going to be a webinar on the 27th of July at 10:00 A.M., Central. It's going to be hosted by the AMA's board chair, Dr. Sandra Fryhofer from Atlanta, and also AMA's vice president of government affairs, Cindy Brown, as well as Jason Marino, our director of Congressional affairs.

We're really going to dig deeper into what are some of the underlying causes of the instability, the difficulty in the current Medicare physician payment system and have a conversation about how physicians, as a community, can get together and advocate to Congress, to the administration as well, for the necessary improvements in the system.

**Unger:** And you'll find a link to register for that event below the description of this particular episode. Again, don't miss that webinar on Wednesday, July 27 at 10:00 A.M., Central to talk more about Medicare reform. And we'll of course, put that on demand when it's completed. You can also find that guide to our rational approach to Medicare reform on the AMA website.

Switching gears, Todd, to another big challenge that physicians are facing, let's talk about what's happening in the wake of the Dobbs decision which essentially overturns nearly half a century of precedent protecting patients' right to critical reproductive health care.

I know that AMA President Dr. Jack Resneck is testifying before Congress on this issue as we speak. How is the AMA advocating for physicians in response to this decision?

**Askew:** Well, thanks for that, Todd. And this is certainly in the health care field, and perhaps larger, one of the most consequential decisions we've seen out of the court in a very long time. AMA is strongly advocating and working to protect patients' rights to reproductive health care and physicians' ability to provide for those patients' needs.

Dr. Resneck, as you mentioned, is testifying in front of the subcommittee, a subcommittee of the Energy and Commerce Committee about that very issue right now. The fact of the matter is, and it's been our longstanding principle, that decisions like these are between patients and their physicians. And these are decisions that take place in the exam room.

And the federal government, the state government, nobody should be in that exam room with that patient and that physician while they are working through and talking about what can be a very
difficult, very difficult decision. Unfortunately, we have a lot of states, a lot of folks who see it differently and they believe that the government does have a role in making some of these health care decisions. And so, we're working, talking with states, all states really, across the country right now, state medical associations, as we work through what does this decision mean. And it's obviously going to mean something different in every state. There are a number of states where the implications of this means they're likely to see a vast increase in patients coming to their state for reproductive health care services that are no longer available in their home state. And so, they're figuring out not only, how do they help provide for that potential increase in needs but also what do they have to do to protect the physicians and those patients that come to their state from efforts by those in other states to somehow punish them or hold them accountable for care that is not permitted in the state from where the patient came? And it's a very complicated issue surrounding that.

Of course, on the other hand, probably more significantly for most, is our states where abortion procedures are now illegal or extremely limited in the ability of patients to access those services. The problem is that for year after year after year, states have passed law after law after law, setting up different regimes to limit or deny access to these services. And now that the courts have basically removed the federal constitutional protection to access these services, states, many of them don't know what their law is. And if the state attorney general, if the state governor can't even articulate how all these different laws they may have passed over the years come together and what it means for their state, physicians find themselves in a really impossible situation.

Even if the law is clear though, in terms of limiting access or to abortion services, the physicians are finding themselves in impossible situations between their ethical and professional obligation to meet the health care needs of their patients, frequently patients for whom there may be serious health care consequences and what the law says may be an ambiguous law, maybe not an ambiguous law.

But in state after state that we talk to, a lot of people just don't even know what the law means. And this is not just limited to a case of elective abortion. But there are questions about EMTALA, there are questions about prescription drugs that may have indications for abortion but are also used for other reasons, whether those can be prescribed.

We've already heard reports of pharmacies not stocking some drugs that are used for care other than abortion care or physicians feeling like they need to take their patients off of pharmaceutical agents that may have a side effect of miscarriage and whether or not they would be charged with something in violation of state bans on abortion. So right now we are in a very confused state.
And it's very confused, 50 states, if you will because the laws are so unclear as to what this means. It is going to take a long time to work out. And so we will continue to have conversations with each state medical association and with many, many specialties who are also engaged in this to try and work through the situation, provide our best guidance, determine the best course for advocacy and find out, figure out how we can best support and meet the needs of physicians, and most importantly, obviously their patients in this time.

**Unger:** Well, you talked a lot about complications, lack of clarity, one of the areas where that exists definitely is around privacy protection. Can you give some comments on that?

**Askew:** So,yeah, Todd. Thanks for the question. Digital privacy is just a huge concern. It has been a concern not only in the context of the Dobbs decision but it's something we've been talking to the administration and Congress about for quite some time.

There are a lot of apps out there, for example, that patients use to track their health care conditions, their menstrual cycles, for example. And people willingly put their personal health care information into these apps without the understanding that the information they are sharing with these third parties does not have the same protections that are afforded under HIPAA for example to their medical record at their physician's office.

And so, while that may have meant one thing pre-Dobbs now that some of this information could implicate someone who has received, for example, an abortion in a state where it may not be legal, I think that the concern about who has access to this information, who can subpoena this information, for example, is a lot more—it's a lot more important for people right now.

So, the administration has put forward some guidance on what information must be shared and cannot necessarily be shared. But also, Congress is getting in on the act and working to advance digital privacy legislation as well to bring some clarity, and very importantly, some understanding to consumers that this information that they are putting out there about themselves is not something that just remains in their phone or in their personal record.

That many of these services can take this information and sell it and use it for other purposes which clearly takes on a much more significant meaning in the post-Dobbs world.

**Unger:** I guess people are discovering that there's a big difference between the physician/patient relationships and the app/patient relationship.

**Askew:** Absolutely.

**Unger:** Very much concerned about that. Well, we'll continue to cover this and also hear about Dr. Resneck's testimony firsthand when he joins us next. That wraps up today’s episode. Thank you,
Todd, for being here and for all the important work that you and your team continue to do on behalf of physicians.

To learn more about the AMA Recovery Plan for America’s Physicians visit ama-assn.org/recovery. We’ll be back soon with another Moving Medicine video and podcast. Thanks for joining us today. Please take care.

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