AMA Advocacy Insights webinar series: Medicare payment principles—A vision for reform

Featured topic and speakers

The Medicare physician payment system needs an overhaul to remedy financial instabilities impacting physician practices due to the pandemic, statutory payment cuts, lack of inflationary updates and significant administrative burdens. To define the goals of reform, the AMA and 120 state medical and national specialty societies created the “Characteristics of a Rational Medicare Physician Payment System.”

Hear about what these principles call on Congress to do to improve the Medicare physician payment system in this webinar. The webinar digs deeper into some of the causes of the current systemic issues and charts a path forward.

Questions were also answered during a live Q&A session at the end of the webinar.

Learn more about the Medicare physician payment principles.

Moderator

- Sandra Fryhofer, MD, chair, AMA Board of Trustees

Speakers

- Cynthia Brown, vice president, AMA Government Affairs
- Jason Marino, director, AMA Congressional Affairs

Transcript

Dr. Fryhofer: Hello everyone and welcome to AMA's Advocacy Insights webinar, Medicare Payment Principles: A Vision for Reform. I'm Dr. Sandra Fryhofer, board chair of the American Medical

Association. I'm in private practice, general internal medicine in Atlanta. And like so many of you, these last two years have tested the limits of our resolve.

In early spring, in many areas, we seem to be making some progress. COVID cases were decreasing. Mask mandates were lifted in some states. And collectively, we breathed a long awaited sigh of relief. But unfortunately, we're still engaged in the battle to keep COVID cases down and take the best precautions we can to prevent COVID transmission. That means we must continue to urge our patients to get vaccinated and boosted with COVID vaccines when they become eligible.

For physicians, our commitment is two part, first to provide quality care to our patients, and second, to make sure we have adequate systems in place that allow us to do just that. Medicare physician payment is one of those systems that must work and it doesn't.

We need a Medicare payment system that's financially sustainable and responsive to our needs. And right now, it's not. We need a Medicare payment system that's responsive to inflation. And we also need inflation-based updates. We need a system that acknowledges the gap between frozen physician payment rates and rising inflation and medical costs.

The current Medicare physician payment system is not sustainable and it threatens patient access to the care they need. The good news, AMA is not alone in its position that Medicare must do better by its physicians. A number of state and specialty medical societies have also coalesced around a roadmap to change the system and fight against future Medicare cuts.

Our panel today will discuss some of those efforts, including characteristics that should be part of a rational Medicare payment system. These principles represent the first stage of organized medicine's efforts to develop and propose substantial changes to the Medicare physician payment to improve the financial viability of physician practices and ease administrative burdens on physicians.

These efforts, as well as webinars like this, are important steps that support physicians and allow our voices to be heard. Last year, thanks to advocacy efforts on the part of AMA and other leading medical organizations, we were able to avoid devastating cuts to Medicare payments scheduled for January 1, 2022.

Because of our efforts, Medicare cuts totaling nearly 10% were averted. These cuts would have been untenable during normal circumstances but were beyond reckless during the public health emergency we continue to face. Averting these cuts was an important sign of progress but additional work is necessary for permanent payment reform.

We'll talk about these issues with today's panel of subject matter experts. Joining us today is Cindy Brown, vice president of AMA government affairs. Cindy is responsible for developing, leading and executing legislative strategy and activities for AMA including necessary Medicare payment system

reforms.

In addition to leading AMA's advocacy work, Cindy uses her extensive experience in policy to determine where and when legislative and regulatory action is advisable. Also with us today is Jason Marino, AMA's director of Congressional affairs.

Jason's job is advocacy. He advocates to members of Congress and their staff to help ensure AMA-supported legislation is enacted, adopted and/or modified to align with AMA policies. Cindy and Jason will begin with an overview of these issues and then we'll move on to the Q&A session.

So if you have chats along the way or questions along the way, please put them in the Q&A function and we'll have time for questions at the end of the panel discussion. So Cindy and Jason, many thanks to both of you for being here. Cindy, I'll start with you.

When MACRA was signed into law seven years ago, there was real optimism that the annual Medicare physician payment crises were over. No more SGR formula threatening cuts of 20% or more every year. But now it seems we're slipping back into the same old annual pattern with smaller but still significant cuts threatening the stability of physician practices every year. How did we get here?

Brown: We got here because there are statutory flaws still in the formula. Under the SGR system, physicians were punished if the volume of services grew faster than some allotted amount of the growth in GDP. Now we've got the problem where other things that were in the law still weren't changed by MACRA that we're suffering with.

For example, there are no statutory updates every year. Right now physicians are in a period where they get no inflationary update. Their update every year is zero. And then any performance adjustments based on MIPS or anything like that are subtracted from zero. So if anything happens, you're going to go below zero.

We also have a problem with what we call budget neutrality. Any time other services are added to the fee schedule, or any relative values are changed or payment policies changed, CMS looks at it, decides if it's going to increase spending, then they have to cut payments for services across the board.

And we've seen that most recently when the office visit services were revalued. And they had new payment policies and so forth. More money going out for E&M services meant that other services had to be cut. It was also designed to steer people towards alternative payment models. That's why the updates are not generous or non-existent.

And, unfortunately, there are no alternative payment models for most physicians to join. And so they're stuck in a rock and a hard place. And then, of course, they began with legacy programs that were

already in existence, tried to create a new program called MIPS and it didn't work out very well. It's administratively burdensome. And then again, you've got a period of high inflation. You've got the COVID impact on all physician offices and so forth. And we just found ourselves in a situation that's unsustainable.

Dr. Fryhofer: Well, it sounds like the law needs a complete overhaul. So, Jason, giving that it's an election year and time is short, is Medicare reform even feasible before the next round of cuts are scheduled to take effect?

Marino: So I don't want to be the bearer of bad news but the Congress, House and Senate are about to fly off for their August recess. They're going to go back home and listen to constituents. And then they're going to come back in September. And there's about 12 legislative days in September.

And then at the end of September, they're going to go back home in October to campaign for the big midterm elections. And then they'll come back maybe a week after elections for a lame duck session. But before the election, there is very little time.

And it's just not realistic or feasible to think we're going to get the massive overhaul of the Medicare physician payment system this year. And we also have to get through some very significant cuts that, unless Congress acts by the end of the year, those cuts go live January 1.

So we have our hands full just with the cuts at the end of the year. And the point of this whole, the webinar, is that we need to take advantage of this August recess when the members start going home, where they need to hear from physicians that, "Hey, this is a problem."

I often talk to members, and every once in a while, I'll be talking to a senator or House member. And I'll give my talking points. And they'll say, you convinced me. But can I give you some advice? It would really help if we heard from physicians, especially physicians back home.

It would really help if other groups are flooding us with issues that—it's great talking to you Jason in D.C. but it would be great to have some—and that's what the point of this is to get the physicians out there talking about it, trying to break through.

A lot of issues and a lot of challenges in our country right now and a lot of issues competing for our members attention. And we have to really put this on the radar. Everything Cindy talked about is not on the forefront of a member's mind right now. And the point of this exercise and this August recess is to break through and make the case.

Dr. Fryhofer: So what kind of cuts do we anticipate seeing in 2023, Jason? I know it sounds kind of sad but what do you see might be happening?

Marino: It's a confluence. It's a portfolio of cuts, unfortunately. And I'll try and walk you through it so the audience can understand what we're facing. And the first big cut, it's related to—it's called budget neutrality that Cindy mentioned.

And there was an increase in E&M services. And then because of the statutory requirement, it triggered across-the-board cuts to all physician services. And for the last two years, we were able to stave off these cuts of 3.75 in 2020 and 3% last year. And now we are facing that 3% again. And there's a new cut, a 1.5% cut, because now they readjusted the E&M services for nine office space services for hospital, home health, nursing homes.

And that led to across-the-board cuts of 1.5. So now you add the 3% plus 1.5. That's 4.5% cuts across the board for physicians. And that's one series of cuts. Then there's the idea of that we're statutorily frozen until 2026, when there'll be a 0.25, not 2.5, 0.25—it's frozen until then. And so you have a cut and then you have a freeze.

And then the other cuts that people haven't seen, because during COVID a lot of things that were in the MIPS space, the merit-based incentive program, the modified fee-for-service program that most physicians are in, they give you a score so to speak. And based on your score, they give you a plus up or a cut. And it could be, if you get the bad score—and it could be through no fault of your own. But you get the bad score, it could be a 9% cut.

And so that hasn't happened yet because that was all delayed but that goes live again. And then there was a $500 million pool of money, if you were a high performance—you had high performance on your metrics, you got—there was a bonus money that went around. And that would help, that was designed to help, if you do get cut one year, at least there's a pool of money that you can get. But that all goes away and the cuts go live.

And then on the other side of the MACRA payment system is alternative payment models. And when MACRA was passed, there was a 5% incentive payment. If you were successfully participate in the APM program, you get a 5% Medicare bonus to all your Medicare payments.

That's a strong—and that's needed because as a physician, you're taking on risk. You could lose. So this is the drive. But the problem is, the APMs, for many reasons, never really came online. Some did. There's some good ACOs out there but a lot didn't materialize yet. And note, that provision expires.

And then also related, it expires at the end of the year and the 5% goes away. And that 5% can make the difference whether you can stay alive or not as an APM. And then there's also another part of that. It's the threshold. It's the formula to determine, did you successfully participate or not?

And it goes from 50% to 75% of your practice has to be APM patients or revenue from that. It's such a high bar that two years ago, we were able to get it frozen at 50% and not the 75%. And what it means

is it's so high, no one's going to meet that metric and you're not going to get the 5%.

So it goes hand in hand. You can extend the 5% bonus but then you never meet the requirements. So what good is it? So they're paired. So those are two separate cuts in a way. So it all comes in different angles but it's coming from the MIPS side, APM side. It's all exacerbated by the fact that there's no payment update at all.

Dr. Fryhofer: Wow. So, Cindy, can you tell us what AMA is doing now to lay the groundwork for comprehensive Medicare payment reforms?

Brown: The document you see on the right is available. It's posted on our website. We'll give you the URLs in a while. But this is something you can use as a handout in some of your conversations. But one of the things we did, we recognized this was coming last fall and started getting together with certain state specialty societies to try and sell the case for reform.

And everybody agreed that that's what we needed to do. And so we started coming up with, what are the things that we would want? What are the characteristics of a good Medicare payment system? And we came up and agreed with those. 122 state specialty societies signed on to them.

Very briefly, the goal of Medicare payment system overall of reform should be simplicity, relevance, alignment and predictability, not only for us but also for CMS. Because we think a lot of the problems we're seeing is that the system we have is so complicated that even the Medicare agency can't quite implement it correctly.

And then, of course, main goals of ensuring financial stability, predictability, promoting value-based care and safeguarding access to high-quality care. And what we mean by that is that all practices can provide high-quality care, whether they're big systems, whether they're hospital based, whether they're solo or small, independent practices, they're all important to the system.

And so we have to make sure whatever we design can work in all those settings and allow all of them to thrive. And I think it's important to go over some of the principles in detail. So can we have the second slide? Okay, this is the beginning of that document so you can see.

But what we mean by ensuring financial stability? We need a baseline positive annual update that reflects inflation. There is such a number. It's called the Medicare Economic Index. But it doesn't factor at all into physician payment rates. So we need to get back to an annual update based on the Medicare Economic Index.

We also make sure that a lot of the behaviors that they're trying to incentivize from physicians are intended to save money across all parts of the system. I mean, that's what preventive care, for example, is all about. What we need to get some credit for the money that we save, not just the money

we spend.

We also want to encourage collaboration, cooperation, patient choice. We don't want to keep squeezing practices so that so many of them leave that you have no choice but to go to a for profit kind of entity. Next slide, please.

We want to reward the quality of patient care, rather than just the check the box exercises that people have to go through that's in the MIPS. We want to encourage innovation. There are lots of ideas for alternative payment models that haven't been accepted.

Physicians have come up with 30 ideas. Of all of them, about half of them were recommended to Medicare to implement. And none of them have been. So, again, that's our problem with the alternative payment models. We want to have physicians get access to their timely data. So that if the goal really is for quality improvement, then you have to get the data on your performance so you know where you need to improve.

And right now, they failed miserably on that, even though there are provisions in the law to make them do it. We want to recognize the value of clinical data registries because they do have real-time quality feedback and physicians can use that. And we want to safeguard access to high-quality care.

Again, we want to make sure that payment models are flexible enough to deal with problems with the social drivers of care, reducing health disparities and so forth, give more support to physicians who care for historically marginalized, high risk, or hard-to-reach populations, rather than getting penalized for doing. So risk adjustments, another way to put it. And, again, we want to recognize that high-value care is provided everywhere.

Dr. Fryhofer: So thank you for reviewing those principles. So, Jason, how can physicians help? How can we physicians help tell this story?

Marino: Let me step back. So I worked on several of the slides with the AMA team, the handouts that you can use on these and walking through the issues. But just to kind of step back a second, in the last 24 hours, I had the opportunity to talk to three different senators and a House member.

And I try to do it, approach it with, I have all these slides. What would a physician that's back home in August is about to talk to a member of Congress, how's that going to go? What's the mind frame? And one thing to just point out before you're about to talk to the member is just to recognize where they're coming from, that they have so many issues that they're responsible for.

They do not know all the payment formula for hospitals, and physicians, and nursing homes, and home health, and then Medicaid and all of the different things, that's just health care. What about Ukraine and the—they have a lot on their plates and they're not experts at all. So when you come at

them—and we're exercised about some of these budget trials. It's outrageous.

But they don't even know that it's outrageous because they don't even know what that means. So you have to step back and realize that they're a blank slate. You want to create some empathy. And I think the bigger picture is, you have to start with making a connection with your own story, what this means to you as a physician or how you're situated, and what it means for your patient access, and humanize it in a way that only you can do that we can't do.

And I lead a team of top-notch lobbyists. And we can get the talking points perfect. And as a constituent, you don't have to get the talking points perfect. In fact, if you're too good it looks too polished. It's not good. You want to be authentic and speak from the heart or speak from your personal experience in this.

And so I would use these documents to help yourself get comfortable with some of the level of cuts and where they're all coming from but you don't need to be an expert on all of the ins and outs. Big picture is, a member may not understand all these payment formulas for Medicare.

But why is it that physicians are the only provider in all of Medicare that doesn't get an update? Why? 9% inflation and there's no update? Why is that? And the reason is, from years ago, decades ago, this was all set up. But why is that? How do you defend that? And then on top of that, last 20 years we've had no update basically. We've lost to inflation. And then to add insult to injury, there's going to be a 4.5% cut, really?

And then there's more cuts coming. We got cuts last year. Why are we always facing cuts and no one's up to date? What does that mean to me? Because there's some skepticism about, is there really a patient access problem? Is that just, Jason, you and your lobbying team making stuff up?

Because it's not like there's a big metric that's a smoking-gun metric that shows you there's a big access problem. You have to explain it to—well, because they say, well, everyone participates in Medicare. Well, you have to as a physician participate in Medicare because you can't have a practice or sustain it without Medicare patients.

But you can be forcing people to retire early because they can't sustain a practice. You could force them to have to give up their practice because they can't—they have to pay your staff. They have inflation costs. You have to increase their wages. Your equipment costs, everything goes up. And you want to stay viable. And you want to be there for your patients in that rural practice but you could go away, or you can retire early or get reformed in a way that patient doesn't have access anymore.

And what about innovation? It's hard to innovate when you're in this financial pressure like this—and then not knowing from year to year. And we don't want to be here asking for money every year at the end of the year. And members of Congress don't like it.

So we want to get these cuts addressed. But we want to get in a way that is a down payment, a bridge to a permanent solution so we have a normal functioning system like the hospitals and nursing homes, and home health, that they don't have to come to Congress every year. When there's inflation spike, their formula adjusts for that.

And so why can't we get to that place? And bring it big picture like that. And you have the materials. If someone wants to dive deep, you have all of that. But I wouldn't get caught—this is not a debate society where you're trying to get every point in. It's about connecting.

And you have a lot of credibility as a physician people respect physicians. They like and trust physicians. And you're telling them that this is a big problem because we're trying to break through and create, because right now they're not seeing it. It takes a while to get these things, it's just the opening salvo of a big campaign throughout the whole fall.

But it really helps to have your voices, your unique voices back home and telling it in a way that you can tell it best because you know your own story. And one final advice I would say is to prepare maybe a 30-second commercial, like 30-second version of what you're going to say and a five-minute version, just in case you're in a situation where you're walking and they're talking to you, and you don't really have their full attention or you only have two minutes, five minutes.

Just always have that ready so you're not thrown off when you realize they've got a bolt for some reason. All it takes sometimes. I have some of the best interactions with senators in 45 seconds. And I've connected. I've made the point. And that's all it takes.

But that chart that's on your slide here, that just tells the story. We have senators now talking about this chart, ... people bringing it up. That's how you know it's resonating, where this chart shows you the last 20 years and where physicians stand versus the other Medicare providers.

And everyone that sees that chart realizes, that's not a sustainable path. And they understand immediately where you're coming from. And then you have that chart and then you're going to cut us? No wonder we're up here. And it says it and it's broken through. All the charts we've done, it's one of the best.

And so I always fall back to that if I'm really being pressed. But you have a great story to tell. It's so important. It's so important that you're doing this. And you keep following up. After an August meeting, you follow up in September or October and really keep pressing, pressing on with the members and their staff.

Dr. Fryhofer: So certainly inflation is in just about every headline we see these days. And so what you're saying is speak from your heart. Make that connection with your legislature. And we've got these fabulous documents with all the details. And I agree. That graph says it all. A picture says

thousand words. And what's happening to physicians is just not fair.

So it's now time for our question and answer part of this discussion. And I'm going to start with some questions that were sent by those of you watching when you registered. And then we'll go to questions, if there's time, that are in the Q&A today.

So first question, are there any plans to roll back sequestration? Cindy, Jason, which one of you wants to take that one?

Marino: I'll jump on that one.

Dr. Fryhofer: Thanks.

Marino: So this is a tough one. And this is something that got set a decade ago when they were trying to deal with the budget deficits and the national debt. And they reached a deal where they were going to have these across-the-board cuts.

And we lived with them for a long time. And then when COVID hit, it really obviously hit everyone hard, hit the hospitals, hit all the providers hard. And sequestration is a 2% cut across the board for all the Medicare providers. And it hit in a way that they realize that they needed to give some relief.

And so we got some relief in some of the early COVID packages. And then last year when we were facing again, we were told 2020 was the last year but that was it. And we kept pressing. We were told, you're not getting more.

And we kept pressing. And we were told, physicians don't get all of it. Some hospitals get it and they don't need it. And you can't—it's a crude, across the board plus up. And we kept pressing. And we got it at the last minute last December.

But they put it, they did it in a way that for the first three months until March, through March you had a 2% relief. And then through July till July 1, you had 1%. And then we're in July, and now we're at the full 2%. And that was their way, bipartisan, they all shook hands, so to speak and they've all agreed that no more sequestration.

And we always bring it up because it's the context. It's a cut. But it's not politically viable and no one is talking about or seriously considering extending it right now. If things change and COVID gets worse, we can always bring it back potentially. But right now, it's not, unfortunately.

Dr. Fryhofer: Okay, next question, budget neutral must apply to all cost centers are no cost centers, it cannot be limited to physician payments only. How did this come about and what is a realistic plan to fix it? Which one of you wants to take that one?

Brown: I can take that one. Oddly enough, other provider categories, ACS, hospital outpatient departments, hospitals and so forth, do have budget neutrality. But their payment systems are remarkably different than ours. They're in big payment groups. So changes don't have the same kind of impact.

They also start out with positive updates. So instead of getting a 4 and 1/2% cut, they may get a 1 and 1/2% cut. But it's coming from a number that's positive, so they still end up getting a positive update every year. We're starting at 0 and we have a lot more fluctuation.

And that's part of why we're—one of our principles is that we want predictability and stability in payments because physician payment changes to drastically from year to year. We need to be able to count on revenue for several years, if you want physicians to be able to invest.

In terms of what we're asking for, we have a three-pronged ask. And it gets kind of technical. But one of the things we want to do is, one of the biggest problem we've had is that CMS, the Medicare agency, has overestimated the uptake of new services that were put in the fee schedule, sometimes by many billions of dollars. And so the budget neutrality adjustment is far more than the actual experience turned out to be.

And so one of the things we want to do is create a mechanism to go back and revisit that, and to fix those problems when they occur and to get the money back in the fee schedule. We also want to better define what services are subject to budget neutrality because we think too many of ours are. And so that those are the things we're going to be pressing for in long-term reform.

Dr. Fryhofer: Okay, next question. With impending Medicare insolvency, a $32 trillion national debt and expanding entitlements in 2026, why is there an expectation of improved physician compensation?

Marino: I'll jump at that one. And this highlights the reality, the political reality we face. It also emphasizes the importance that being bipartisan and having relationships with all sides because it could be a change in power next Congress.

And a big issue is, there's $32 trillion or so in national debt. There's significant budget deficits. We have a lot of challenges. And how do we fit in there? And just one of the members of Congress recently I mentioned earlier brought to light to me in a way that he said, there should be a new budget chair.

And one of the candidates, he sees his role as he's going to be the new chair. There's a change of power and he's going to take on the debt and deficit. And then he's like, my job is to work with him but also work with you. And I have to juxtapose that debt issue and deficit spending going down and paying for physician formula.

We've got to make it work. We've got to thread the needle. And it can be done but it's not going to be easy because what you're asking for, what we're asking for, is maybe hundreds of billions and billions, tens of billions, $100 billion, just the nature of it because the way the Congressional Budget Office scores things. They score things over a 10-year period.

And so if you give physicians an update that reflects inflation, an MEI update, it costs a significant amount of money. And we have to make the case and create the political will that even if you're on a track to reduce the deficit and the debt, you still can find room to address this issue.

And we have to create the will to make that happen and make members want to do that, and not just dismiss us as, we can't afford this. We have to find a way to frame it and do the patient access argument. And you can argue that if you do nothing—this was my response—if you do nothing, the practices go away, physicians retire, they restructure, maybe they restructure in a way that they find higher reimbursements in a different structure.

And that cost of that could be actually significantly higher than what you have now in the fee for service with physicians in the office setting. So you have to think about that too. The CBO doesn't score that. So there's a cost of inaction as well that could hit the debt. And so we realize there's challenges, and we're cognizant and humble about it. But these are real issues that have to get addressed.

Dr. Fryhofer: You're so right. I mean, this current system is unsustainable. All right, next question, how do we overcome the physician mentality that this is a zero-sum game for physicians? We are entitled to lobby for better reimbursement without criticizing or attacking the reimbursement of others.

Medicare reimbursement has not kept up with inflation over the past 30 years but staff salaries and office expenses, malpractice and inflation have increased annually. How do we solve the conundrum, which also contributes to physician burnout? And I know you've been talking a lot about that today but just crystallize a few points for this listener.

Brown: Well, I think they made the case there. Physicians should not have to live in a zero-sum game. And when we talk about the price of everything and so forth, honestly, it's the price of doing business. They're going to have to start covering these costs.

And so as Jason was mentioning earlier in terms of explaining the impact of all this on your staff, on your staffing needs and your ability to supply your offices and so forth, that's what they need to do. And we're not ... we never attack other providers. There's no point doing that. We're all in the same thing. We're all taking care of patients.

But that is one of the problems we run into is that they like to offset the cost of these things. And sometimes they come from other providers, particularly the hospitals, who have a positive update as

you can see in that—what we call the gap chart that Jason saw earlier.

I mean, that's the reality of what we're facing but that's not the reality of what were asking. We're not asking for those people to get cut. But the fact is, the argument that's made here in the question is the argument that members of Congress have to hear. And they need to hear it directly from members, from our members, so that they can identify with it and appreciate it. And they'll understand how it affects their constituents.

Dr. Fryhofer: Okay, next question, why do hospitals receive both a professional and facility fee for E&M codes, whereas private practice physicians only receive a professional fee, much lower in value than the combined reimbursement that hospitals receive?

Brown: That has to do with the resource-based relative value scale on which physician payments are based. Every physician service has three sets of relative values, one for their work, which is measured in terms of time and intensity of providing the service—one in terms of their practice cost and one in terms of their malpractice premiums.

When those services are provided in another facility, they take away the physician practice expenses. And so the physician is getting paid only for their work. And the hospital then does have practice expenses. You're providing the service in the hospital, so you get the hospital's practice expenses.

Their practice expenses are higher than a physician's office. Which gets to the point Jason was making earlier. You drive more physicians out of private practice and more of them become employed, it's going to cost Medicare more because they're going to be paying the higher practice costs in hospitals that they don't have to pay for in physician offices. So that's a feature of the different payment systems.

Dr. Fryhofer: Okay, are independently physician-owned ASCs paid at the same rate as hospital-owned ASCs. The same question for outpatient health care facilities that are not ASCs. Are hospital-owned paid at a different rate than physician owned? And if so, how can this be fixed?

Do hospitals have an inflation adjustment built into their payment rates? I think you've shown us that graph is yes. Do physicians in their practices? I'm thinking about that gap graph.

Brown: Yeah, exactly. Hospital's ASCs, outpatients department, all that, their payments are closer. They're not identical but they're much closer together than when those services are provided in a physician offices. And some of it is the legacy of what we've lived with, with the fact that our updates haven't kept pace with inflation and theirs have.

And, again, as I mentioned, they also have a different system. They batch a lot of different services together to come up with what their payment rate will be, versus looking at every individual service the

way the physician-fee schedule does.

Dr. Fryhofer: Next question, are we anywhere near stopping the fee-for-service payment plan for a more just compensation to nonprocedural specialties?

Brown: The E&M services, the increases we just had that are causing this budget neutrality cut are a big part of that. I mean, that was the whole intention of doing that, as well as now they're looking at the facility-based visit services.

There's also new codes coming into place for extraordinarily complex visits. That's going to come into effect in 2024. So there are a lot of efforts underway, again, to try and improve payments for high-value cognitive care.

Dr. Fryhofer: Next question, would a universal health care plan such as Medicare for all solve this issue or at least make the issue easier to solve?

Brown: I vote no. I think the problem there is that the people who are running this program now that we're trying to fix, they designed it. We're having all these arguments to try and fix it. I don't see how it's going to be better if they have more of your revenue, jurisdiction over more of your revenue.

I think you're going to run into more politics being featured into coverage decisions. As the political winds change, what's covered, what's not will change, what the priorities are and so forth. And you're going to have to argue with the halls of Congress every single year for every single patient you have. And that's not a battle I relish. Jason?

Marino: I would just add that I think to make the math work because the CBO score for that would be very, very high, they would have to—it has to be more pressure on physician payments. They'd have to go down significantly to make the math work. And then you'd have all the problems we have now, which is for all payments with Medicare. And that's not a great place to be.

Dr. Fryhofer: All right, this is a long question from one of our registrants. I'm a very active member of the Alliance for Patient Access. We all physicians know, pre-authorization is illegal, unethical, adversely disrupts patient care. It sacrifices the practice of medicine for a scam and financial greed of insurance companies. It caused a great harm to patients over two decades.

Physicians are demoralized and have burnout, impose much higher costs to our practices, and at the same time, it's deprived patients of much deserved treatment prescribed by their physicians. Why can't we physicians at the AMA get this stopped? We've been discussing the same at their meeting for the Alliance for Patient Access.

Marino: I'll take this one. I can bring some good news here. So we hear that on the prior authorization. And so just today, moments from now, the House Ways and Means committee is going to mark up our bill, the prior authorization bill and Medicare Advantage addresses a lot of the concerns. It brings a lot more transparency and rationality to the system.

And we've seen drafts they're marking up. And they're very favorable. And it's a significant improvement. And it's been a long time coming. We did slow and steady. We got 300 cosponsors on the bill. We have a Senate bill by Senator Marshall, Dr. Marshall, that has 40 cosponsors.

And we have a lot of momentum right now. And we are hoping and praying that at the end of the year, in the lame duck session, in addition to our cuts being addressed and prevented, we also get a bill passed to address prior authorization and Medicare Advantage. And we are well positioned, the best we've been in years, to do that. And so we're just keeping the pressure on but I like where we're headed.

Dr. Fryhofer: Well, it's great that we get this live update. It can't get better than this to know exactly what's happening today. So another question, if seniors who vote are concerned about loss of access caused by this, this could be an important item for those facing re-election. We should look at doing some political ads that point this out and encourage seniors to reach out to their congresspersons, also to encourage them to block this. So that's more of a comment. But what's your reaction to that comment?

Brown: I can tell you that we do have a database of patients in our grassroots database and those who really do seem to care about these issues. And, honestly, they respond to our call of actions in greater numbers than physicians do as a percentage. They really are helpful.

But there's only so far you can go with it, because whenever payments go up under the Medicare program, that means premiums go up. And so working with the organizations who, like us, are trying to, represent their members can be a little difficult when we try and put any pressure on premiums.

We do have plans—not right now. We're talking about fixing the problems we're looking at in January. But the principles are about total payment reform. And this is what we're going to be doing after that. And in there, we're going to be working to try and identify the messages that really work well with patients, and try and get them engaged.

For a short-term routine end of the year fight, probably less of that, except through our grassroots network. Jason, I don't know if you have anything to add.

Marino: I'll just add that any patient that calls in to weigh in on this is political gold. It's hard to get that to happen, that moment when they actually call in on this issue, it is worth a lot. It goes back to that conversations I've had, members are like, it would be helpful if you have people calling in and if you

get the patients calling in, that is gold. And it helps move the needle.

Dr. Fryhofer: And send them a copy of that gap graph, which to me is so powerful. Another question, in addition to resourcing physicians to advocate and share their stories, what is the overall advocacy plan from the AMA? Would you be sharing sign-on letters? Do you want health care organizations to join you in this advocacy? And if so, what's the strategy in involving them?

Brown: Well, we have to a great extent. I mean, that's why we have 120 organizations signing onto our principles. And we're working with several different coalition groups. There's one we're working with that also includes the non-physician providers who are also affected by the fee schedule. And then we work more closely with the physicians for obvious reasons.

And all those things are under way. There have been some sign-on letters. There's one pending now that's going to be sent up to Capitol Hill to demonstrate the reform, our common messaging. And we're having joint meetings with people and so forth. So this is routine part of business that we do. But you will see an awful lot of reports on us collaborating with others.

Dr. Fryhofer: Thank you for that. This is a great question. What about Medicare Advantage plan to get an 8% update and potential 5% bonus based on star rating, yet deny care and procedures, how does that affect budget neutrality?

Brown: It doesn't. That's Medicare Part C, not Part B. It's not part of the fee schedule. But it's part of the story that we're telling, in terms of, health plans get an 8% update when everybody says—insurance companies are doing pretty well following the pandemic. They've got—you know. And so it factors into our story. We've been collecting all that update information to share. But it doesn't factor into budget neutrality. It doesn't hurt physicians, it just doesn't help.

Marino: You're wondering, probably, where do these formulas come from? Who designed this? And it wasn't like someone sat down at one point designed all these things, because you wouldn't design it this way. But budget neutrality, why does that affect just us in this unique way?

And it's because of some bill. And I worked in the Senate where you're cutting a deal. And it's late at night, 2:00 in the morning. You've got to get a certain number that CBO says. And you draft in $20 million, what's going to trigger price neutrality. And that's kind of what happened.

And then it went in effect in 1992, 30 years ago. And now we're just living with this thing. And that's where it came from. And we're 30 years later, and everyone's just like, I don't know where it came from but this is the rule of law today. And Medicare Advantage plans don't have that. And it's just a tough spot where we're in. And these histories like that, middle of the night 30 years ago.

Dr. Fryhofer: Well, it sounds like somebody was asleep at the switch in 1992. Maybe we need to get a little more caffeine to Congress if they're going to be working at that time of morning. And thank you so much for putting up the links of ways to connect to contact Congress and to learn more about these issues.

Cindy and Jason, this has been a great discussion. But, unfortunately, we're out of time. We'll be talking more about Medicare physician payment reform in the weeks and months ahead. Many thanks to our fabulous panel and to each of you for joining us today for this important conversation about where we are, what we need and what happens next. We'll continue to keep you informed about other opportunities to engage around this and other topics that impact America's physicians. Thank you and have a great rest of your day.

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