



# Medicare physician payment reform

The American Medical Association is deeply alarmed about the growing financial instability of the Medicare physician payment system due to a confluence of fiscal uncertainties physician practices face related to the ongoing pandemic, statutory payment cuts, lack of inflationary updates, and significant administrative barriers. The payment system is on an unsustainable path threatening patient access to physicians.

- According to an AMA analysis of Medicare Trustees data, Medicare physician payment has been reduced 20% adjusted for inflation from 2001–2021. The Medicare physician payment system is lacking an adequate annual physician payment update similar to other Medicare providers. A continuing statutory freeze in annual Medicare physician payments is scheduled to last until 2026, when updates resume at a rate of 0.25% a year indefinitely, well below the rate of medical or consumer price index inflation.
- A May 2021 *JAMA Health Forum* study found that it costs an estimated \$12,811 and more than 200 hours per physician per year to comply with the Medicare Merit-Based Incentive Payment (MIPS) system and to date there have been very limited options for physicians to move to the value-based Medicare Alternative Payment Model (APM) payment system.
- The resulting discrepancy between what it costs to run a physician practice and actual payment combined with the administrative and financial burden of participating in Medicare is incentivizing market consolidation and driving physicians out of rural and underserved areas.
- In addition to being asked to do more with fewer resources each year, physicians also continue to face significant clinical and financial disruptions during the COVID-19 pandemic. In 2020, according to an AMA study, there was a \$13.9 billion decrease (equating to a 14% reduction) in Medicare physician fee schedule spending as patients delayed treatments. Burnout, stress, workload, and fear of COVID-19 infection are leading one in five physicians to consider leaving their current practice within two years.

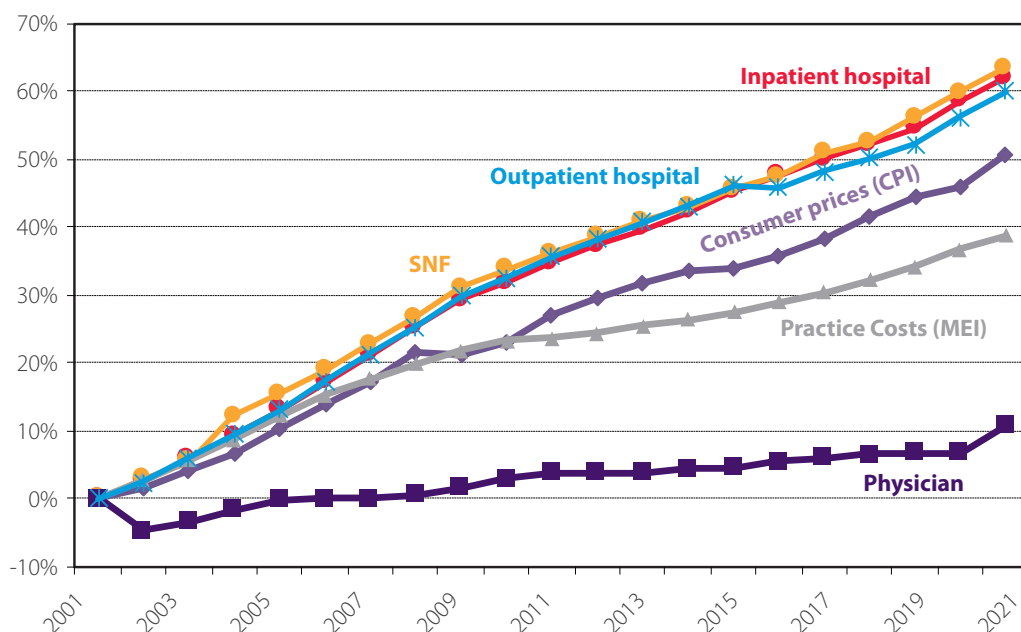
**Therefore, it is urgent that Congress work with the physician community to develop solutions to the systematic problems with the Medicare physician payment system and preserve patient access:**

- At a minimum, Congress needs to establish a reliable Medicare physician payment update each year that keeps up with inflation and practice costs and encourages innovation.
- Policymakers should work with the physician community and other stakeholders to develop ways to reduce the administrative and financial burden of MIPS participation for physician practices under the Medicare fee-for-service program and ensure the program's clinical relevance to patient care.

**Policymakers should consider ways to make the Medicare APM program more viable, including passing the H.R. 4587, the Value in Health Care Act of 2021.** When Congress passed MACRA in 2015, it included 5% bonus payments to incentivize participation in APMs to deliver high-quality care while generating savings for the Medicare program. Unfortunately, to date the development and availability of APMs for physicians to participate in has been extremely limited. The physician community is committed to continuing to work with the U.S. Department of Health and Human Services to expand the availability of value based APMs and remove barriers to participation. Congress can help this process by passing the bipartisan VALUE Act, which would extend the 5% APM incentive payment program for six years to 2030 and make further improvements to encourage increased physician participation.



## Medicare pay updates compared to inflation (2001–2021)



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

According to data from the Medicare Trustees, Medicare physician pay has increased just 11% over the last two decades, or 0.5% per year on average. And roughly one-third of that increase is the temporary 3.75% update for 2021 that will expire in 2022. In comparison:

- Medicare hospital updates totaled roughly 60% between 2001 and 2021, with average annual increases of 2.4% for both inpatient and outpatient services.
- Medicare skilled nursing facility (SNF) updates totaled more than 60% between 2001 and 2021, or 2.5% per year.
- The cost of running a medical practice increased 39% between 2001 and 2021, or 1.6% per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, is measured by the Medicare Economic Index or MEI.
- Economy-wide inflation, as measured by the Consumer Price Index, increased 51% over this period (or 2.1% per year).

As a result, Medicare physician pay doesn't go nearly as far as it used to. Adjusted for inflation in practice costs, Medicare physician pay declined 20% from 2001 to 2021, or by 1.1% per year on average.

AMA Economic and Health Policy Research, October 2021



# Reducing prior authorization burdens

Prior authorization, or the practice of insurance companies reviewing and potentially denying coverage of medical services and pharmaceuticals prior to treatment, remains a principal frustration for physicians and jeopardizes patient care. According to a 2021 American Medical Association (AMA) survey, physicians complete an average of 41 prior authorizations per week, an administrative burden that consumes nearly two business days of physician and staff time. The burden has become so acute that 40% of physician survey respondents hired staff to work exclusively on prior authorization requirements.

The AMA believes that medically necessary clinical services and prescriptions covered by health insurance plans should be administered without delay. Prior authorization undermines physicians' medical expertise and leads to considerable delays in patient care. According to the 2021 survey, 93% of physicians reported care delays associated with prior authorization, and 82% said these requirements can at least sometimes lead to patients abandoning treatment.

Failure to administer medically necessary care can lead to poor health care outcomes. Most startlingly, 34% of AMA survey participants reported that prior authorization led to a serious adverse event, such as hospitalization, disability and permanent bodily damage, or death, for a patient in their care.

## Improving prior authorization in Medicare Advantage

Since Congress is increasingly concerned about the negative impact of prior authorization on patients and physicians within federal health care programs, a bipartisan collection of House and Senate lawmakers introduced H.R. 3173/S. 3018, the Improving Seniors' Timely Access to Care Act. This bill reduces unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program. In addition, the legislation, which currently has more than 260 bipartisan cosponsors in both the House and Senate, incorporates all major elements of a 2018 consensus statement developed by leading physician, hospital, medical group, health plan, and pharmacy stakeholders.

More specifically, the bill would:

- Require Medicare Advantage plans to implement electronic prior authorization programs that adhere to newly developed federal standards and are capable of seamlessly integrating into electronic health systems (vs. proprietary health plan portals), as well as establish real-time decision-making processes for items and services that are routinely approved
- Mandate that plans report to the Centers for Medicare & Medicaid Services on the extent of their use of prior authorization and the rate of approvals and denials
- Require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based guidelines, permit gold carding, and include continuity of care for individuals transitioning between coverage policies to minimize any care disruptions
- Hold plans accountable for making timely prior authorization determinations and providing rationales for denials

**Urge your representatives and senators to cosponsor H.R. 3173/S. 3018, the Improving Seniors' Timely Access to Care Act—bipartisan, bicameral legislation that reduces the burden of prior authorization within Medicare Advantage and promotes patient access to timely, high-quality care.**

To access the AMA's prior authorization research and advocacy resources, visit [ama-assn.org/prior-auth](https://ama-assn.org/prior-auth).



# Tell Congress to make expanded access to covered telehealth services permanent

The success of telehealth adoption during the COVID-19 public health emergency makes it clear that Medicare telehealth benefits should remain available to patients after the pandemic is over.

However, unless Congress acts, most Medicare beneficiaries will abruptly lose access to these services when the public health emergency ends. That is because under section 1834(m) of the Social Security Act, Medicare patients must live in an eligible rural location, and travel to an eligible “originating site”—a qualified health care facility—in order to access telehealth services covered by the Medicare program. Congress authorized the Secretary of the Department of Health and Human Services (HHS) to waive these restrictions, but they will kick back in when the public health emergency (PHE) expires.

Physician practices have built successful telehealth systems that are making health care more accessible and convenient for patients—we should not turn back now. The American Medical Association (AMA) supports legislation that would permanently fix the originating site and geographic restriction on telehealth coverage for Medicare patients, thereby ensuring patients can continue to access Medicare telehealth services regardless of where they are located, including:

- H.R. 1332/S. 368, the **Telehealth Modernization Act of 2021**, which would lift the rural-only restriction and add any site where a patient is located as a potential originating site
- H.R. 2903/S. 1512, the **CONNECT for Health Act**, which would lift the rural-only restriction, add the home as an originating site, establish a process for the Secretary of the HSS to add originating sites, and provide HHS with the permanent authority to waive section 1834(m) restrictions.

The AMA also supports H.R. 4058/S. 2061, the **Telemental Health Care Access Act**. This important, bipartisan bill would repeal a new requirement that a patient must see a provider in person within six months of receiving a mental health telehealth service. This medically unnecessary requirement was included in the December 2020 OMNIBUS legislation without vetting from expert stakeholders. It should be repealed before it takes effect when the PHE expires.

**Action request: Urge your members of Congress to cosponsor H.R. 1332/S. 368, the Telehealth Modernization Act of 2021, H.R. 2903/S. 1512, the CONNECT for Health Act, and H.R. 4058/S. 2061, the Telemental Health Care Access Act.**





# Tips for an effective meeting: The six 'Ds'

**Conducting an effective meeting with members of Congress requires preparing for the conversation by staying on message and doing so succinctly. Remember the six "Ds" to maximize your persuasiveness.**

**1. Discovery**—Research your lawmaker to understand their interests. Reviewing their website, newsletters and social media accounts ahead of time will give you a sense of what issues are important to them.

**Tip:** Their last 10 tweets could provide a sense of their most immediate concerns. Check it out.

**2. Determine**—What do you have in common with the lawmaker? How might the legislative ask appeal to the interests of the legislator or their constituents?

**Tip:** By doing the legwork and finding some common ground, you may find new ways to frame your ask that result in better advocacy outcomes.

**3. Develop**—Write out a conversation flow that includes your ask and key points you will make. Remember to frame the issue in a manner that relates to the legislator's interests.

**Tip:** Use the Key Interests-Based Advocacy formula below to guide your messaging:



**4. Drill**—Rehearse your ask and supporting arguments several times before the meeting. Be concise. Think about how to overcome any objections made by the office.

**Tip:** Consider recording audio or video of yourself on your smartphone to help refine your approach and align your body language.

**5. Delve**—Schedule and conduct your meeting, remembering to lead and close with your legislative ask.

**Tip:** Always try to secure a commitment from the office during your meeting, even if it's just to learn more about the issue, and share when you next plan to contact the office.

**6. Don't Forget to Follow Up**—Contact your state medical society staff (or the AMA) for answers to any unanswered questions raised during the meeting. Provide that information to the office right away and schedule your follow up with the lawmaker.

**Tip:** Not knowing the answer to any questions asked by your legislator provides a convenient opportunity to follow up with the office. Should you not know the answer to a question, assure the legislator that you will obtain that information and report back to the office.