



Congress must prioritize Medicare physician payment reforms in 2023

The American Medical Association is deeply concerned about the growing instability of the Medicare physician payment system due to statutory payment cuts, lack of inflationary updates and administrative burdens. The physician payment system is on an unsustainable path that threatens patient access to physician services.

Last year, physicians faced yet another round of real dollar Medicare pay cuts triggered by the flawed Medicare budget neutrality rules and congressional PAYGO rules. Congress acted at the last minute to avert portions of the 8.5% cut—but didn't stop the cuts completely. Physicians will be cut -2% in 2023 with additional cuts in 2024. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, the value of **Medicare physician pay fell 22%** from 2001–2021 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

Piling on these latest cuts in the midst of high inflation, workforce shortages, and soaring physician burnout will have negative consequences as older Americans struggle to find access to the primary care physicians and specialists they need. The cuts will disproportionately affect small, independent, and rural physician practices, as well as those treating low-income or other historically minoritized or marginalized patient communities.

This pattern of last-minute stop gap measures must end. Last year, the AMA responded to a bipartisan **Congressional Request for Information (RFI)** on strategies that federal lawmakers should consider to stabilize Medicare physician payment, reduce regulatory burden, and improve the Medicare Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs. The AMA stands ready to work with Congress on solutions to fix this discrete set of problems within the Medicare physician payment system.

Action request

Medicare physicians and patients should not have to face the uncertainty of annual cliffhangers or constant threats of additional cuts. Ask your Members of Congress to:

- Support legislation to provide an annual Medicare physician payment update equal to the full Medicare economic index (MEI), the index used by the Centers for Medicare & Medicaid Services to measure physician practice-cost inflation.
- Urge Congress to hold hearings early this year focused on fixing problems with the Medicare physician payment system—including reforming the budget neutrality rules, providing an annual update that reflects practice cost inflation, reducing administrative burdens, and improving the MIPS and APM programs.



Oppose federal legislation that expands health care provider scope of practice

The American Medical Association remains committed to promoting federal policies that preserve physician-led teams as the primary way to provide high-quality patient care. In general, the AMA strongly opposes federal and state efforts to expand the scope of practice of non-physicians, typically referred to as allied health professionals, into areas that constitute the practice of medicine.

While allied health professionals play an important role in team-based health care, the high-stakes field of medicine demands education, expertise, acumen, coordination and robust patient management that can best be delivered by a physician-led team. Data shows that patients are justifiably concerned about the cost and quality of care, especially medical diagnoses, delivered by non-physicians. Recent AMA surveys found that 91% of patients view physicians' education and training as vital for optimal care, 75% would wait longer and pay more to be treated by physicians, and 95% said it is important for physicians to be involved in their diagnosis and treatment. With requirements to complete four years of medical school, three to seven years of residency, and 10,000-16,000 hours of clinical training, physicians are undoubtedly the most qualified and crucial part of a patient's health care delivery team.

The unique challenges of the COVID-19 pandemic accelerated ongoing efforts by federal policymakers to either temporarily relax or even permanently alter scope of practice laws making this issue that was once concentrated at the state level an ever-increasing concern at the federal level. However, the various rationales cited to justify expanded scope of practice policies, such as increased access to care and lower costs, are incorrect.

For example, many policymakers claim that allowing allied health professionals to practice without physician involvement will increase access to care in rural and underserved communities.

- The AMA, however, mapped the locations of primary care physicians and nurse practitioners (NPs) nationwide in 2013, 2018, and 2020 and each time the results showed that they tend to practice in the same areas of the state as physicians, irrespective of scope of practice laws.

Another misconception is that there are no other policy options to increase access to care in underserved areas.

- In reality, there are a multitude of ways to enhance access to physicians outside of expanded scope of practice including: telehealth expansion, increasing residency positions, enhanced loan forgiveness programs for physicians in rural and underserved communities, and supporting students from underserved areas to pursue medical education.

Finally, expanding allied health professionals' scope of practice leads to higher health care costs.

- A robust analysis of data from the Hattiesburg Clinic, an accountable care organization (ACO) and multispecialty clinic in Hattiesburg, Miss., found that care provided by non-physicians working on their own patient panels led to higher costs, more referrals, higher emergency department use and lower patient satisfaction than care provided by physicians. More specifically, Hattiesburg Clinic found that ACO spending was nearly \$43 higher per member, per month for patients with a non-physician primary care practitioner compared to those with a primary care physician, which equated to an additional \$10.3 million in spending annually.

Scope of practice bills in the 117th Congress

Below is a summary of a select cohort of scope of practice bills opposed by the AMA last Congress.

H.R. 8812, the Improving Care and Access to Nurses (ICAN) Act: Introduced by former Rep. Lucille Roybal-Allard (D-Calif.), this broad, sweeping bill effectively removes physicians from important decisions in care for Medicare patients by authorizing nurse practitioners (NPs), certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNS), and physicians assistants (PAs) to order and supervise cardiac and pulmonary rehabilitation, establish home infusion services, refer patients for medical nutrition therapy, certify and recertify a patient's terminal illness for hospice eligibility, and perform all mandatory examinations in skilled nursing facilities. This legislation, strongly opposed by the AMA, did not become law.

H.R. 6087, the Improving Access to Workers' Compensation for Injured Federal Workers Act: Introduced by Rep. Joe Courtney (D-Conn.), this legislation sought to allow NPs and PAs to diagnose, prescribe, treat, and certify an injury and extent of disability for purposes of compensating federal workers under the Federal Employees' Compensation Act. Current law prohibits non-physicians from making these determinations and reserves that function for physicians. This bill, strongly opposed by the AMA, passed the House of Representatives, but ultimately stalled in the Senate.

H.R. 7213, the Equitable Community Access to Pharmacist Services Act: Introduced by former Rep. Ron Kind (D-Wis.), the legislation allows pharmacists to test and initiate drug regimens for influenza, respiratory syncytial virus or streptococcal pharyngitis. Pharmacists would also be permitted to administer vaccines and provide related services for COVID-19 or influenza, address public health needs related to public health emergencies, and provide services as determined by the secretary of the Department of Health and Human Services for undefined programs, including closing gaps in health equity. This bill, strongly opposed by the AMA, did not become law.

H.R. 2654, the Chiropractic Medicare Coverage Modernization Act: Introduced by Rep. Brian Higgins (D-N.Y.), this bill would amend the definition of physician to extend Medicare coverage for services furnished by chiropractors beyond manual manipulation of the spine. This bill, opposed by the AMA, did not become law.

The AMA expects that each aforementioned bill will be reintroduced as well as possibly new scope expansion legislation in the recently convened 118th Congress, thus necessitating strong physician grassroots opposition.

Action request

- Urge your senators and representative to oppose legislation, such as the examples above, that would expand the scope of practice of non-physicians at the expense of physician-led teams.



Bipartisan graduate medical education and physician workforce legislation:

Increase residency training slots and reform immigration policies to alleviate physician shortages and serve our aging, growing population

The American Medical Association has long-supported legislation to increase graduate medical education (GME) training slots. GME, which encompasses residency and post-residency fellowships, is the supervised training after medical school that physicians must complete prior to becoming state licensed and practicing independently. The United States is facing a shortage of between 54,100 and 139,000 physicians by 2033—a dearth that is almost certain to be exacerbated by rising rates of physician burnout and early retirement. The physician workforce, much like our general population, is aging, with nearly 45% of active physicians in the United States being age 55 and older. Despite an ever increasing population of seniors in the United States, the Balanced Budget Act of 1997 put caps on the number of federally funded residency training positions, essentially freezing the number of Medicare supported GME slots at levels that existed in 1996. Now, as medical school enrollment grows, aspiring physicians worry about having adequate GME slots available to complete their training prior to serving their communities.

Congress made an initial investment in shoring up the physician workforce by providing 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act, 2021—the first increase of its kind in nearly 25 years. Additionally, the Consolidated Appropriations Act, 2023 provided 200 federally supported GME positions for residencies in psychiatry and psychiatry subspecialties. However, more federal assistance is needed to substantially increase the number of physicians. More specifically, the AMA urges Congress to further invest in the physician workforce by passing the **Resident Physician Shortage Reduction Act** in the 118th Congress (introduced in the 117th Congress by Sens. Menendez [D-N.J.] and Boozman [R-Ark.] and Rep. Sewell [D-Ala.] and former Rep. Katko [R-N.Y.]). This bipartisan legislation would take steps to better alleviate the physician shortage by gradually providing 14,000 new Medicare-supported GME positions over seven years. Much like the 2020 and 2022 year-end increases, these positions would be targeted to hospitals with diverse needs, including rural teaching hospitals, hospitals serving patients in health professional shortage areas, hospitals in states with new medical schools or branch campuses, and hospitals already training over their Medicare caps. With physician shortages continuing to grow across the country, these larger workforce investments are desperately needed and will result in additional care across the spectrum of specialties to help address the holistic health needs of America's patients.

The AMA also strongly supports the **Opioid Workforce Act/Substance Use Disorder Workforce Act** (introduced in the 117th Congress by Sens. Hassan [D-N.H.] and Collins [R-Maine] and Rep. Schneider [D-Ill.] and former Rep. McKinley [R-W.Va.]), which provides 1,000 additional Medicare-supported GME positions over five years in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain management. This bill is critical for medical students to receive appropriate training prior to caring for patients in communities across the country suffering from opioid and related substance use disorders and facing a shortage of physicians trained to treat them.

In the short term, there is also a need to capitalize on investments made in foreign doctors trained at U.S. medical schools. Current law requires these physicians who complete their medical residency in the U.S. on a J-1 visa to return to their country of origin for two years before being eligible to apply for an immigrant visa or permanent residence (Green Card), forcing physicians who have been trained in the U.S. to leave the country even though they are desperately needed. Under the Conrad 30 program enacted in 1994, physicians who agree to serve in a rural and underserved area for three years can receive a J-1 visa waiver and remain in the U.S. after completing their medical residency. For many patients living in underserved communities, international medical graduates serve as the only access point to a physician. Consequently, the AMA supports Congress passing the **Conrad State 30 and Physician Access Reauthorization Act** (introduced in the 117th Congress by Sens. Klobuchar [D-Minn.] and Collins [R-Maine] and Reps. Schneider [D-III.] and Bacon [R-Neb.]). This bipartisan bill reauthorizes this crucial program for three years and makes targeted policy improvements, including permitting expansion of the number of waivers granted to each state, and allows physicians who work in an underserved area or Veterans' Administration facility for a total of five years to gain priority access in the Green Card system, thereby helping to address the current physician Green Card backlog.

Action request

- Urge your senators and representative to co-sponsor the **Resident Physician Shortage Reduction Act**, to ensure the number of physicians trained today will be sufficient to treat the expanding, aging population of tomorrow. Encourage your senators and representative to co-sponsor the **Opioid Workforce Act/Substance Use Disorder Workforce Act**, to significantly increase the supply of physicians trained to meet our nation's immense need for treatment of addiction and related disorders.
- Urge your senators and representative to co-sponsor the **Conrad State 30 and Physician Access Reauthorization Act**, which reauthorizes this important program for international medical graduates for three years, establishes a process for increasing the number of waivers per state, and makes targeted improvements so that rural and underserved communities continue to have access to a physician.