

Restore 2024 Medicare physician payments

Congress must quickly pass legislation to reverse the 3.37% Medicare physician payment cuts that took effect on Jan. 1, 2024. Failure to reverse these cuts will be harmful to the continued viability of physician practices and their ability to care for patients. Entering their fourth consecutive year of payment cuts for Medicare services, physicians are at a potential breaking point.

With repeated reductions in Medicare payments in recent years despite rapidly rising practice costs and the burdens and burnout associated with the pandemic, some practices are already limiting the number of Medicare patients they treat. We anticipate these cuts will be felt hardest by small, independent practices, like those in rural and underserved areas. Continuing down this path is simply unsustainable.

Physicians and other clinicians who are paid under the Medicare Physician Fee Schedule are the only Medicare provider group that did not receive an inflation update this year. In fact, they are the only ones who have a payment cut in 2024.

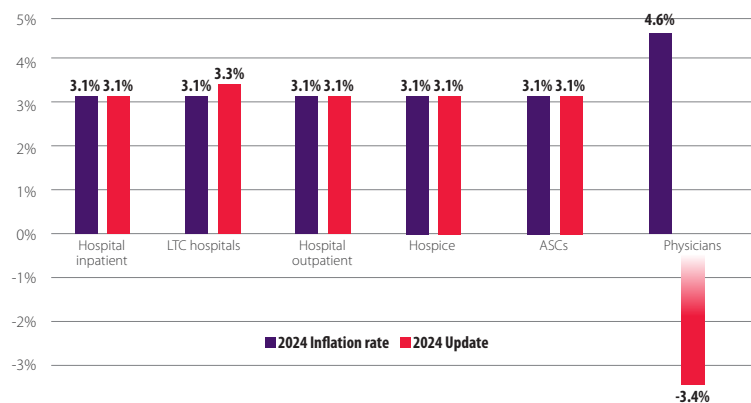
Medicare provider updates for 2024

Note:

Hospital inpatient, LTC hospitals, hospice, hospital outpatient and ASC inflation rates reflect market basket less a productivity adjustment.

Physician fee schedule inflation rate is the Medicare Economic Index, which has a productivity adjustment.

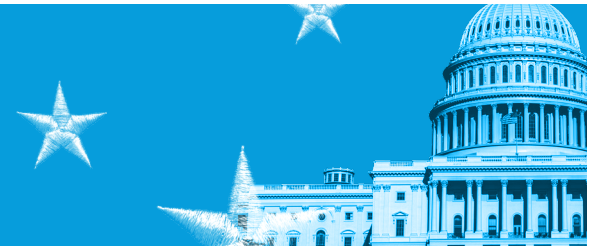
Potential adjustments for quality performance omitted for all provider types.



We appreciate efforts by members of the House and Senate to preserve Medicare patients’ access to physician services through introduced legislation that stops these impending cuts, hearings on the flawed Medicare payment system and “Dear Colleague” letters urging Congress to expeditiously pass bills halting the reductions. In fact, nearly 200 Members recently wrote Congressional leadership asking for the cuts to be stopped.

Congressional asks:

- **Work together and quickly reverse the CY 2024 Medicare physician and other Part B clinician cuts to preserve access to care in the Medicare program. Anything less than full relief from the cuts negatively impacts our nation’s seniors. The physicians and the Medicare patients they treat deserve better.**



Congress needs to enact Medicare physician payment reforms in 2024

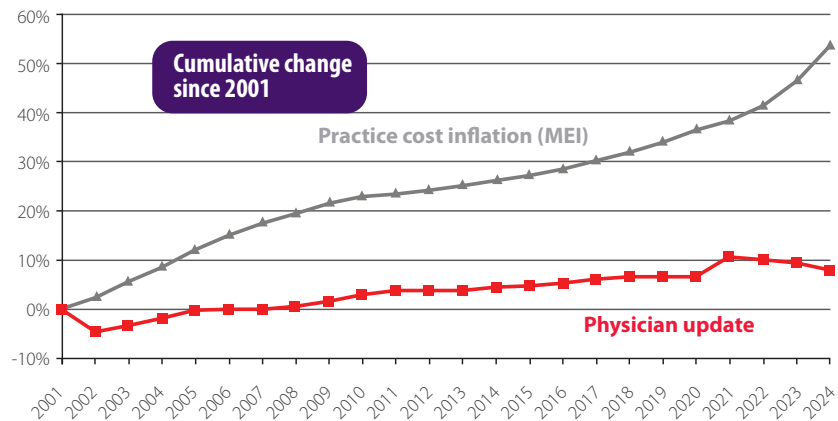
The American Medical Association is deeply concerned about the growing instability of the Medicare physician payment system due to statutory payment cuts, lack of inflationary updates and administrative burdens. The physician payment system is on an unsustainable path that threatens patient access to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

Physicians faced yet another round of real dollar Medicare pay cuts triggered by the flawed Medicare budget neutrality rules and congressional PAYGO rules at the start of 2023. Congress acted at the last minute in 2022 to avert portions of the 8.5% cut—but did not stop it completely. Ultimately, physicians were cut 2% in 2023 and Congressional relief has not yet been delivered to reverse the additional 3.4% cut that took effect on Jan. 1, 2024.

These collective cuts come on the heels of two decades of stagnant Medicare payment rates. Adjusted for inflation in practice costs, the value of Medicare physician pay fell 30% from 2001–2024 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update. Piling on the latest 3.4% cut during a period of high inflation, workforce shortages and soaring physician burnout will have negative consequences as older Americans struggle to find access to primary care and specialist physicians they need. The payment reductions disproportionately impact small, independent and rural physician practices, as well as those treating low-income or other historically minoritized or marginalized patient communities.

Medicare updates compared to inflation in practice costs (2001–2024)

Note:
Adjusted for inflation in practice costs, Medicare physician payment declined 30% from 2001 to 2024.



This pattern of Congress passing last-minute stop gap measures to avert the negative impact of budget neutrality adjustments to the Medicare Physician Fee Schedule (MPFS) that, at best, result in a payment freeze must end. Last year the AMA, together with all 50 state medical associations and dozens of national physician organizations, endorsed a shared set of principles to reform Medicare reimbursement entitled, “Characteristics of a Rational Medicare Physician Payment System.” This document was the precursor to work with members of Congress and the committees of jurisdiction on legislative proposals to: (1) provide automatic annual inflation updates to the MPFS Conversion Factor (CF) based on the Medicare Economic Index (MEI); (2) revise policies for maintaining budget neutrality within the MPFS that have necessitated

corresponding payment cuts; (3) ease the administrative burdens and fiscal uncertainty caused by the Merit-based Payment Incentive System (MIPS); and (4) extend incentives that enable physician practices to participate in alternate payment models (APMs).

More specifically, Congress introduced a collection of commonsense legislative reforms that build upon “Characteristics of a Rational Medicare Physician Payment System” including:

H.R. 2474, the Strengthening Medicare for Patients and Providers Act, introduced by Reps. Raul Ruiz, MD (D-Calif.), Larry Bucshon, MD (R-Ind.), Ami Bera, MD (D-Calif.) and Mariannette Miller-Meeks (R-Iowa), would provide an annual, automatic update to the MPFS based on the MEI. The legislation also replaces the differential conversion factors for MIPS (e.g., 0.25%) and APM (0.75%) participants that are set to begin in 2026 with the MEI inflationary update.

H.R. 6371, the Provider Reimbursement Stability Act, introduced by Rep. Greg Murphy, MD (R-N.C.) and 14 original cosponsors, would reform MPFS budget neutrality policies by: (1) requiring CMS to reconcile inaccurate utilization projections based on actual claims and prospectively revise the CF accordingly; (2) raise the threshold that triggers a budget neutrality adjustment from \$20 million to \$53 million and increase it every five years by the cumulative increase in the MEI; (3) require the direct inputs for practice expense relative value unit (i.e., clinical wages, prices of medical supplies and prices of equipment) to be reviewed concurrently and no less often than every five years and (4) require CMS to limit positive or negative budget neutrality adjustments to the CF to 2.5% each year.

H.R. 5013/S. 3503, the Value in Health Care (VALUE) Act, introduced by Reps. Darin LaHood (R-Ill.) and Suzan DelBene (D-Wash.) in the House, and Sens. Whitehouse (D-R.I.) and Barrasso (R-Wyo.) in the Senate, would extend the 5% APM bonus and maintain the 50% revenue threshold for two years.

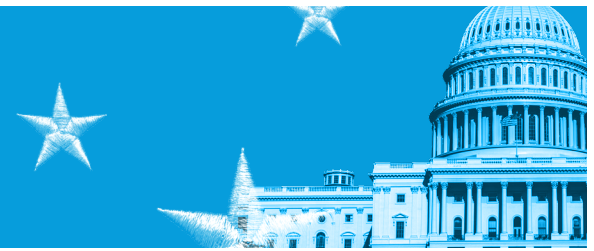
H.R. 6683, the Preserving Seniors’ Access to Physicians Act, introduced by Reps. Greg Murphy, MD (R-N.C.), Danny Davis (D-Ill.), Brad Wenstrup (R-Ohio), Michael Burgess, MD (R-Texas), Jimmy Panetta (D-Calif.) and Larry Bucshon, MD (R-Ind.), would provide full, short-term relief from the 3.4 % cut imposed in 2024 due to the budget neutrality policies medicine is seeking to reform.

Bipartisan support for these legislative proposals continues to grow in Congress. In addition, during markups held on health care issues in the fall of 2023, both the Senate Committee on Finance and the House Committee on Energy and Commerce moved legislation to offset a portion (1.25%) of the 2024 CF cuts along with select provisions of H.R. 6371 to reform fee schedule budget neutrality policies. These proposals await floor action in both chambers. During these markups, members of both committees discussed the need for Medicare payment reform at length and secured pledges from the chairs to address the issue in earnest this year.

The AMA stands ready to work with Congress on solutions to fix problems within the Medicare physician payment system. Medicare physicians and patients should not have to face the uncertainty of annual payment cuts that threaten physician practice viability and patient access to care.

Congressional asks:

- **Ask your senators and representatives to support and urge House and Senate leadership to enact legislation to stop the 2024 Medicare CF cut.**
- **Ask your senators and representatives to urge the committees of jurisdiction to initiate hearings to start the process of long-term Medicare physician payment reforms, including an automatic annual inflation CF update based on the MEI, and revisions to fee schedule budget neutrality policies.**
- **Ask your representatives to cosponsor H.R. 2474, H.R. 6371, H.R. 5013, and H.R. 6683 and urge your senators to support companion legislation in the Senate, including S.3503.**



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. The U.S. is facing a shortage of between 37,800 and 124,00 physicians by 2034—a deficiency that is almost certain to be made worse by rising rates of physician burnout and early retirement. The physician workforce, like our general population, is aging, with nearly 45% of active physicians in the U.S. aged 55 and older. Despite an increasing population of seniors in the U.S., the Balanced Budget Act of 1997 caps the number of federally funded residency training positions, essentially freezing the number of Medicare-supported GME slots at levels that existed in 1996. As medical school enrollment continues to grow, aspiring physicians worry about having adequate GME slots available to complete their training so they can serve 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.

The AMA urges Congress to further invest in the physician workforce by passing H.R. 2389/S. 1302, the **Resident Physician Shortage Reduction Act** introduced by Sens. Robert Menendez (D-N.J.) and John Boozman (R-Ark.), as well as Reps. Terri Sewell (D-Ala.) and Brian Fitzpatrick (R-Pa.). This bipartisan legislation would help alleviate the physician shortage by gradually providing 14,000 new Medicare-supported GME positions over 7 years. Much like the 2020 and 2022 smaller increases, these positions would be targeted to hospitals with diverse needs, including rural teaching hospitals, hospitals serving patients in health professional shortage areas (especially those hospitals affiliated with historically Black medical schools), hospitals in states with new medical schools or branch campuses, and hospitals already exceeding their Medicare supported training caps. With physician shortages continuing to grow across the country, larger workforce investments are desperately needed and will address workforce shortages across the spectrum of specialties to help address the holistic health care needs of America's patients.

The AMA also strongly supports H.R. 7050, the **Substance Use Disorder Workforce Act**, introduced by Reps. Brad Schneider (D-Ill.), David Valadao (R-Calif.), Annie Kuster (D-N.H.) and Mike Kelly (R-Pa.), 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. Although not reintroduced yet, the Senate companion bill, entitled the Opioid Workforce Act, is traditionally led by Sens. Maggie Hassan (D-N.H.) and Susan Collins (R-Maine). 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.

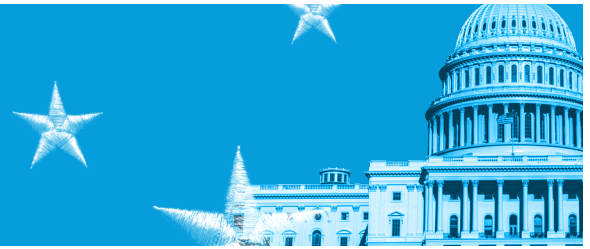
In addition, the cost of attending medical school remains a major barrier for individuals looking to become physicians, especially those from minoritized and marginalized communities. Nearly 75% of medical school graduates have outstanding medical school debt with the median amount being \$200,000. As a result, Congress should pass H.R. 1202/S. 704, the **Resident Education Deferred Interest (REDI) Act**, bipartisan legislation introduced by Sens. Jacky Rosen (D-Nev.) and John Boozman (R-Ark.), and Reps. Brian Babin, DDS (R-Texas) and Chrissy Houlahan (D-Pa.) that permits borrowers in medical or dental residency or internship programs to defer their student loans without interest until completion of their training.

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 a Permanent Residence Card (Green Card), forcing physicians who have been trained here 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 H.R. 4942/ S. 665, the **Conrad State 30 and Physician Access Reauthorization Act**. Introduced by Sens. Amy Klobuchar (D-Minn.) and Susan Collins (R-Maine) and Reps. Brad Schneider (D-Ill.), Don Bacon (R-Neb.), David Valadao (R-Calif.) and Sylvia Garcia (D-Texas), this bipartisan bill reauthorizes this crucial program for three years, makes targeted policy improvements such as permitting an expansion in 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.

Finally, Congress should pass H.R. 6205/S. 3211, the **Healthcare Workforce Resilience Act**. Introduced by Reps. Brad Schneider (D-Ill.), Yadira Caraveo, MD (D-Colo.), Don Bacon (R-Neb.) and Tom Cole (R-Okla.) and Sens. Richard Durbin (D-Ill.) and Kevin Cramer (R-N.D.), this bipartisan bill allows for the recapture of 15,000 unused employment-based physician immigrant visas and 25,000 unused employment-based professional nurse immigrant visas from previous fiscal years (1992–2021). The visas would become available immediately upon the date of enactment of the legislation and remain available for a three-year period.

Congressional asks:

- **Cosponsor H.R. 2389/S. 1302, 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 H.R. 7050, the Substance Use Disorder Workforce Act/Opioid 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 to reintroduce the Opioid Workforce Act.**
- **Cosponsor H.R. 1202/S. 704, the REDI Act, which permits physicians to defer their medical school student loans without interest until the completion of their residency program.**
- **Cosponsor H.R. 4942/S. 665 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.**
- **Cosponsor H.R. 6205/S. 3211, the Healthcare Workforce Resilience Act, which recaptures 15,000 unused employment-based visas for physicians and 25,000 unused employment-based visas for nurses.**



No fees for health plan EFTs

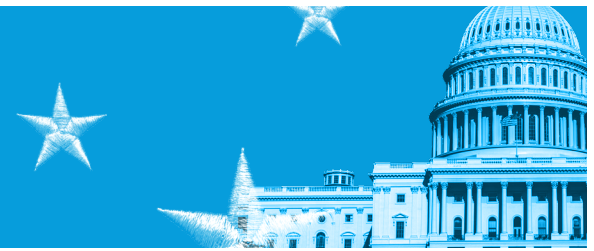
Legislation introduced by Reps. Greg Murphy, MD (R-N.C.), Morgan Griffith (R-Va.), Mariannette Miller-Meeks, MD (R-Iowa), Ami Bera, MD (D-Calif.), Kim Schrier, MD (D-Wash.) and Derek Kilmer (D-Wash.) would bar health plans and vendors from charging physicians unnecessary fees for electronic fund transfer (EFT) payment transactions.

Why it is important: The Affordable Care Act requires health plans to offer medical practices standardized electronic payment (i.e., direct deposit), but some insurers or their vendors are imposing fees of 2% to 5% of the claim payment for practices that choose to be paid through these transactions. Physicians should not have to pay predatory fees to be paid electronically for the services they provide.

Nearly 60% of practices surveyed by the Medical Group Management Association (MGMA) said that they are forced to pay these percentage-based fees without ever having agreed to them. A third-party vendor that health plans require practices to contract with is the entity that most often assesses the fees for purported “value-added services” such as a customer-service hotline. MGMA says that 75% of practices’ annual revenue is paid via EFTs and that the fees can cost a large practice up to \$1 million annually.

Congressional asks:

- **Urge your representatives to cosponsor the No Fees for EFTs Act (H.R.6487) to prohibit health plans from imposing fees on health care providers to get paid electronically.**
- **Urge your senators to introduce companion legislation in the Senate.**



Support the Connected MOM Act

Telehealth and technology enabled devices have proven to be key assets in the physician’s tool box for prevention and improved health outcomes for a number of conditions during the pandemic. The American Medical Association recognizes this same technology is critical to addressing maternal mortality and morbidity by helping screen new mothers for high blood pressure and related treatable and preventable conditions, such as preeclampsia, that lead to unnecessary and avoidable maternal deaths and adverse health outcomes.

The Connected Maternal Online Monitoring (MOM) Act, S. 712, introduced by Sens. Cassidy (R-La.) and Hassan (D-N.H.), would require the Centers for Medicare & Medicaid Services (CMS) to send a report to Congress identifying barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.

Medicaid pays for almost half of all births nationally in the U.S. each year, and it plays a critical role in providing maternity-related services, covering the vast majority of births for women of color and those living in rural areas. The AMA strongly supports this legislation which would make a meaningful difference in addressing the unacceptably high rate of maternal mortality in the U.S., especially for women from marginalized populations.

Congressional asks:

- **Urge your senators to cosponsor S. 712, the Connected MOM Act.**
- **Urge your representatives to introduce companion legislation in the House.**