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March 1, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200
200 Independence Avenue, SW
Washington, DC 20201

Re: Calendar Year (CY) 2025 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure:

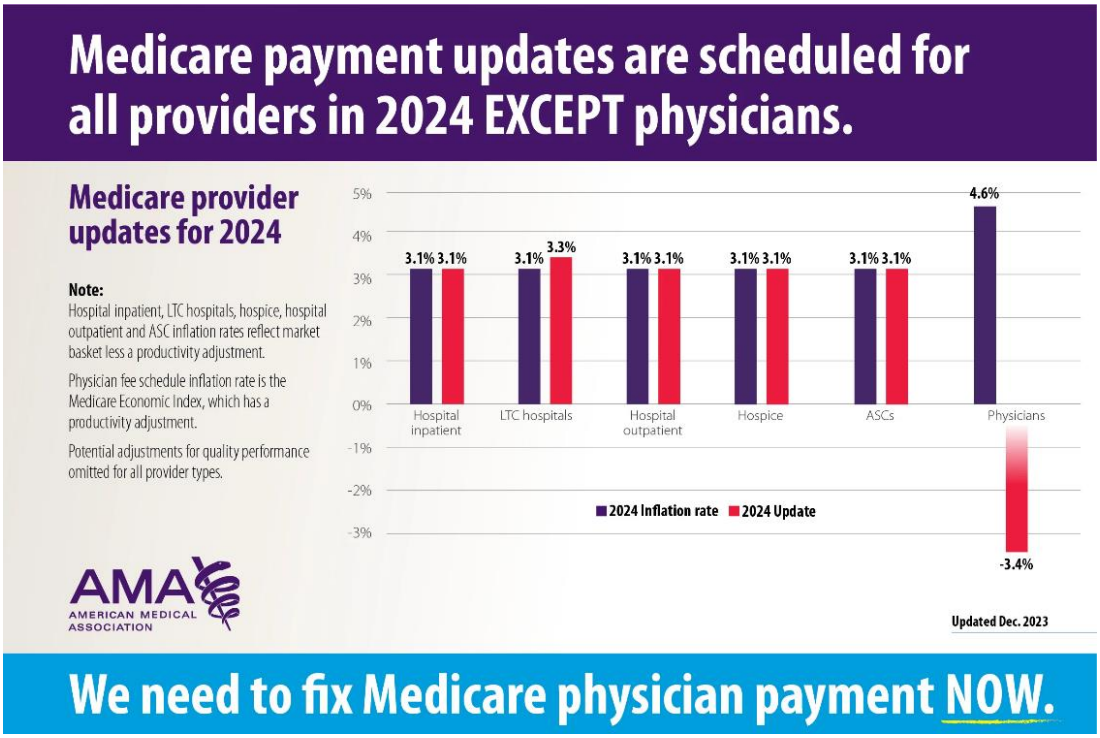
On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2025 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (the Advance Notice) (CMS-2024-0006), issued on January 31, 2024.

In the comments below, the AMA addresses two key issues.

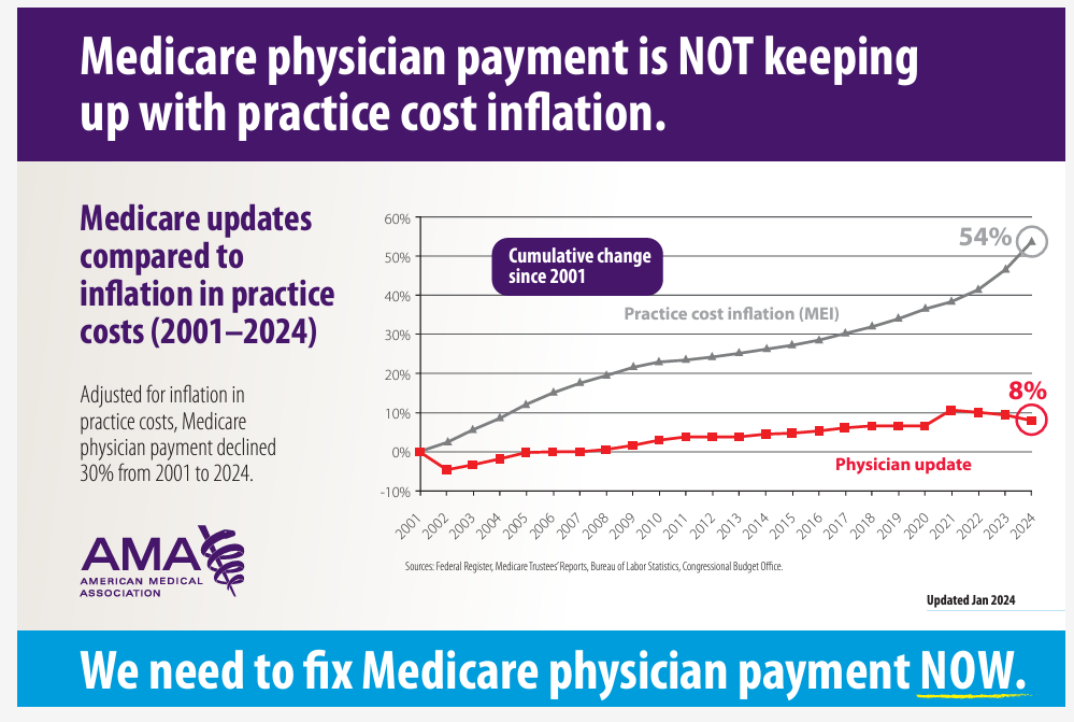
- The AMA has strong concern over the growing discrepancy between the nearly four percent increase in MA rates for 2025 and the repeated cuts in Medicare physician payment rates. This disparity underscores a critical issue: while MA plans see financial growth, physicians face multiple years of cuts and then a freeze in 2025 at the reduced rates, with no adjustments for inflation, putting them at a significant disadvantage. The AMA strongly advocates for and urges CMS to recognize this profound imbalance and take decisive action towards implementing equitable adjustments that accurately reflect inflation and escalating practice costs. This is crucial to safeguarding physicians' ability to deliver high-value care to patients.
- The AMA strongly opposes the inclusion of opioid-related measures in the Medicare Advantage program, citing concerns over patient harm, forced tapering, and delays in care. We recommend the removal of such measures, aligning with recent Centers for Disease Control and Prevention (CDC) updated guidelines and Medicaid program recommendations, to prevent misapplication and to focus on meaningful, patient-centered outcomes.

The AMA finds it difficult to reconcile that the Advance Notice indicates that MA rates are scheduled to increase by nearly four percent in 2025, while in sharp contrast, current law will hold Medicare physician payment schedule services frozen in 2025 after several years of cuts. In fact, physicians are the only Medicare providers whose payments do not automatically receive an annual inflationary update, and they are the only Medicare providers who have a payment cut in 2024. Physician payments are further eroded

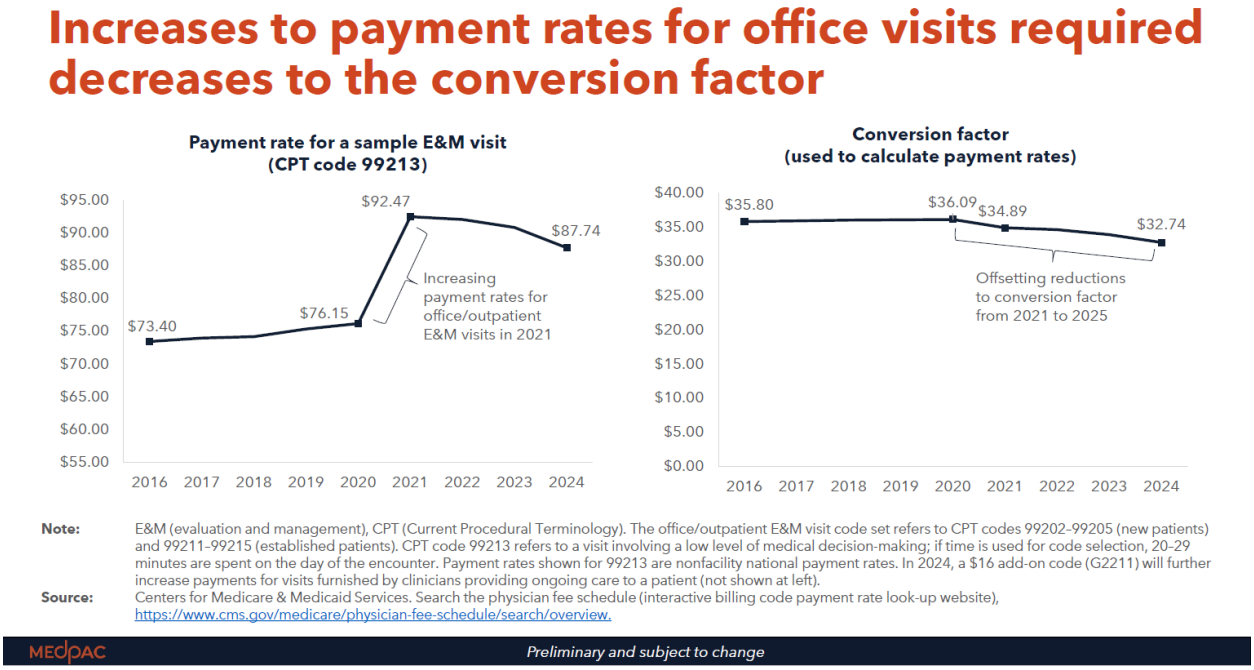
by frequent and large payment redistributions caused by budget neutrality adjustments. Under current law and the final 2024 Medicare Physician Payment Schedule (MPS), the 2024 Medicare physician payment conversion factor was reduced by 3.37 percent on January 1, 2024. This cut coincides with historic growth in the cost to practice medicine with a 4.6 percent increase in Medicare Economic Index (MEI) in 2024.



Physician practices are struggling because Medicare payment has barely budged over the last two decades, increasing just eight percent from 2001 to 2024. Part of this increase is attributable to a 2.5 percent update that Congress provided physicians for 12 months following the passage of the Consolidated Appropriations Act, 2023 (CAA 2023).



The chart below, developed by the Medicare Payment Advisory Commission (MedPAC), also indicates that the payment increases for Evaluation and Management (E&M) services in 2021 have already been significantly eroded by the subsequent reductions to the conversion factor. Although nearly all physicians provide E&M services, these E&M cuts have had an especially severe impact on the primary care physicians that should have seen the most benefit from the historic 2021 revaluation.



In October 2023, MedPAC discussed a range of topics that impact Medicare physician payment, including the lack of an inflation-based update. The Commission expressed near universal support for linking updates to Medicare physician payment to inflation as measured by the MEI. Hospitals, skilled nursing facilities, and nearly every other Medicare provider receive an automatic annual update tied to inflation. Physicians compete in the same marketplaces as these providers for clinical and administrative staff, equipment, and supplies. Yet physicians are at a significant disadvantage due to payment cuts and because their payments have failed to keep up with inflation.

The AMA strongly urges CMS to work with Congress to pass H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which provides a permanent annual update equal to the increase in the MEI. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care. This key legislation will ensure that Medicare provides sustainable funding to physician practices serving patients in the regular Medicare program just as it finances private insurance plans in the Medicare Advantage market.

After three consecutive years of cuts to Medicare services, physicians are at a potential breaking point. Facing a nearly 10 percent reduction in Medicare payments over the past four years and rising practice costs on top of 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 that continue to face significant health care access challenges. Continuing down this path is simply unsustainable.

Use of Opioids at High Dosage in Persons Without Cancer (OHD) / Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) / Concurrent Use of Opioids and Benzodiazepines (COB) / Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D).

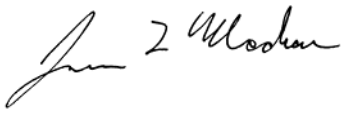
The AMA does not support inclusion of opioid related measures in the Medicare Advantage program. We are glad to see the Pharmacy Quality Alliance (PQA) address concerns with the inappropriate inclusion of cancer patients by testing the measures with cancer exclusions. However, we do not believe the revisions address the ongoing concerns and patient harm the measures are causing. The 2022 CDC revision makes clear that no policy should be based on hard thresholds, including for those exceptions. The reason is that CDC recognized first in 2019, and then codified in 2022 that there was wide misapplication of the 2016 guidelines.

Despite nearly all state laws and other policies having those exceptions (management of pain related to sickle cell disease, management of cancer-related pain, or palliative care or end-of-life care), those patient populations where prescribing opioids is appropriate are continuing to suffer denials, forced tapering, delays in care, and other problems leading to direct harm and stigma. This fact was recently recognized by the Medicaid program as it was recently recommended that the "Use of Opioids at High Dosage in Persons Without Cancer" and the "Initial Opioid Prescribing for Long Duration (IOP-LD)" be removed from the Medicaid Core Measure set starting in 2026 during the Child and Adult Core Sets Annual Review Workgroup meeting. During the meeting CDC highlighted their lack of support for the measures and the numerous problems and patient harm it is causing. The IOP-LD measure was also recently reviewed during the 2023-2024 Measure Under Consideration (MUC) Process and the Pre-Rulemaking Measure Review Clinician Workgroup could not reach consensus which further highlights the challenges with the measure. Workgroup members specifically questioned the evidence base for the measure and the lack of alignment with clinical guidelines.

We also question whether there continues to be room for improvement with the measures. We know the use of opioids and prescribing practices have been reduced and changed since the measures were initially developed due to education and use of prescription drug monitoring programs. CMS even goes on to highlight this fact within the Notice by stating, "PQA may retire the OMP measure due to the very low measure rates, resulting in minimal opportunity for measure improvement. Additionally, due to the narrow range of the measure rates, the measure does not effectively discern good versus poor performance." Therefore, continuing to include the measures in the MA program runs counter to CMS' Meaningful Measures Initiative, which aims to align across programs and/or with other payers (Medicaid, commercial payers), ensure measures are patient centered, and provide significant opportunity for improvement.

Thank you for your consideration of these comments. To further discuss the content of this letter, please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,



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