AMA
AMERICAN MEDICAL ASSOCIATION

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Michael E. Chernew, PhD
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: AMA Comments on April 2024 Meeting–Medicare Physician Payment Update

Dear Dr. Chernew:

On behalf of the physician and medical student members of the American Medical Association (AMA), I commend the Medicare Payment Advisory Commission (MedPAC) for acknowledging the unsustainable trajectory of the current Medicare physician payment system and for exploring ways to increase the default physician payment update to account for the increase in the costs to run a medical practice. We appreciate the opportunity to offer our specific comments on each of the proposed approaches.

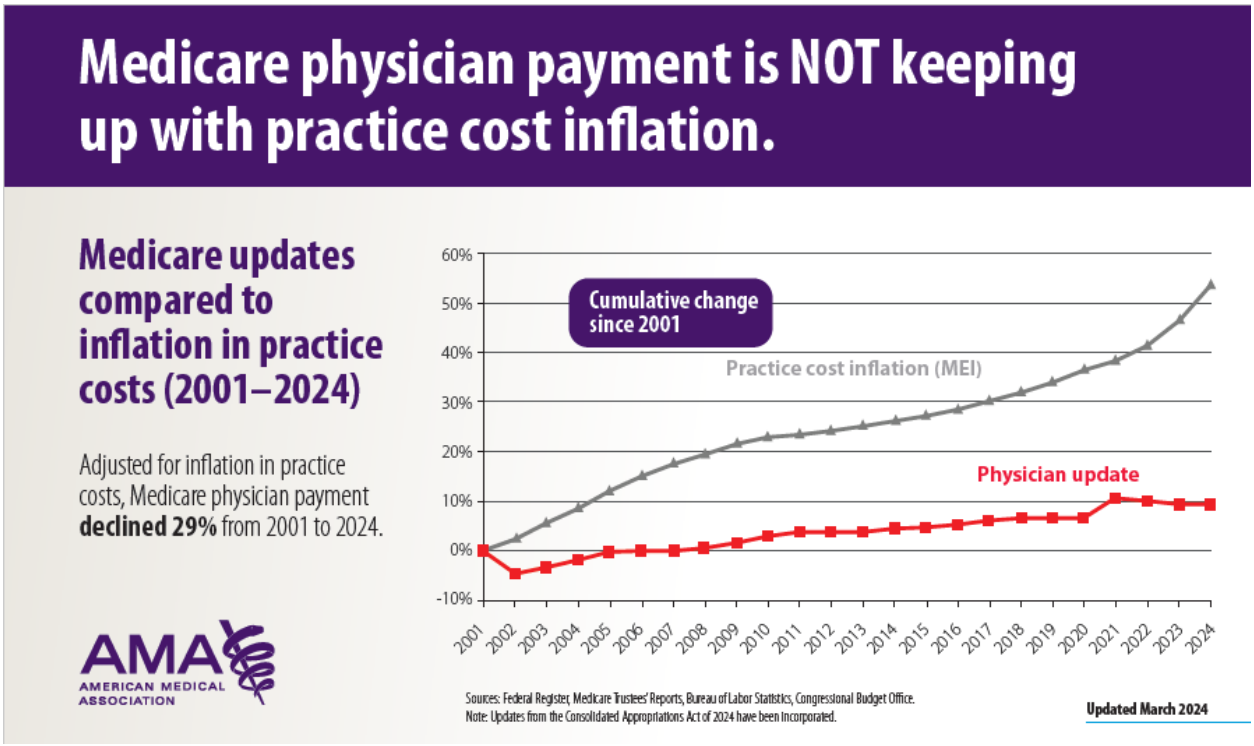
During the April 2024 meeting, MedPAC discussed several options to address the lack of an inflation-based update in the Medicare Physician Payment Schedule (MFS), which would be a significant increase in payment compared to the baseline under current law. The AMA is pleased that MedPAC is discussing overdue reforms to the Medicare physician payment system. We released a statement in support of the Commission's work on this critical topic and its implications for preserving patient access and advancing health equity.

The AMA strongly agrees that an inflation-based update to Medicare physician payment is necessary to keep pace with the increased costs of practicing medicine and preserving access to care. Along with state medical and national medical specialty societies, the AMA developed a set of principles to guide our advocacy for long-term solutions to ensure a rational Medicare payment system that guarantees financial stability and predictability, promotes value-based care, and safeguards access to high-quality care. These shared principles are reflected throughout our comments.

1. **Growing Need for an Inflation-Based Update to Medicare Physician Payment to Preserve Patient Access to Care**

The AMA supports the direction of the MedPAC deliberations at the April 2024 meeting to replace the severely inadequate baseline MFS updates in current law with an annual update that accounts for inflation in the costs of running a medical practice. **The AMA is strongly urging Congress to pass H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which would update Medicare physician payment by 100 percent of the Medicare Economic Index (MEI).** Such an update would allow physicians to keep pace with rising practice costs so they can continue to invest in their practices and implement innovative strategies to provide high-value, patient-centered care.

As the Commission pointed out, the gap between what Medicare pays physicians and the actual costs associated with delivering high-quality care continues to grow. According to data from the Medicare Trustees, Medicare physician payment has increased just nine percent over the last 23 years, or 0.4 percent per year on average. That nine percent includes the temporary 2.93 percent update that expires at the end of this year. In comparison, the cost of running a medical practice increased 54 percent between 2001 and 2024, or 1.9 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, physician compensation, and professional liability insurance premiums, is measured by the MEI. As a result, Medicare physician payment is falling further behind, as shown in the chart below. When adjusted for inflation in practice costs, Medicare physician payment declined 29 percent from 2001 to 2024, or by 1.5 percent per year on average.



Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. According to the Medicare Trustees, if physician payment does not change, access to Medicare-participating physicians will become a significant issue in the long term. Some Medicare patients are already experiencing inequitable delays in care, and we know that when care is delayed, health outcomes worsen. These problems particularly impact minoritized and marginalized patients[1] and those who live in rural areas.[2]

We appreciate Commission staff acknowledging concerns in presentation materials about future access to

[1] See e.g., Johnston KJ, Hammond G, Meyers DJ, Joynt Maddox KE. Association of Race and Ethnicity and Medicare Program Type With Ambulatory Care Access and Quality Measures. *JAMA*. 2021;326(7):628–636. doi:10.1001/jama.2021.10413.
[2] https://rhrc.umn.edu/wp-content/uploads/2019/12/UMN-Access-to-Specialty-Care_12.4.pdf.

care due in large part to the fact that MEI growth is projected to exceed payment schedule updates by more than it has in the past. We also agree with many of the individual Commissioners who identified several limitations with MedPAC's previous findings that access to care for Medicare beneficiaries is satisfactory, including:

- MedPAC's survey findings conflict with other sources of data on patient access. **One recent survey found one in three Medicare beneficiaries had to wait more than a month to see a physician. In the same survey, about one in six beneficiaries said they were told to go to urgent care because their physician had no appointments available.**
- Another survey from 2022 found physician appointment wait times increased eight percent from 2017 and 24 percent from 2004. The survey found it now takes an average of 26 days to schedule a new patient physician appointment in 15 of the largest cities in the United States.
- The comparison in access between patients who have Medicare versus commercial insurance does not indicate that access is adequate for either group of patients.
- The measures of patient access are qualitative, such as "How often did you have to wait longer than you wanted to get a doctor's appointment?" Because beneficiaries' expectations for timely access to primary and specialty care may vary, these measures are subjective and may not tell us the full story about their timely access to care. Moving to quantitative measures (e.g., "How long did you have to wait for an appointment? How many physicians did you have to call before finding one who was accepting new Medicare patients?") would likely reveal a different, worse picture of beneficiary access.
- We agree with Commissioners who have noted that physicians having a "choice" to not accept Medicare patients may be less of an option now, both because it may be a decision made by their employer and because Medicare eligible patients are becoming a larger share of the population.
- Finally, physicians inherently do not want to turn away elderly or disabled patients, particularly existing patients who they have been treating for years while on employer-sponsored insurance. Physicians continue to care for those Medicare patients even if it is not financially viable. It is widely known commercial rates offset Medicare rates and that being reimbursed on Medicare rates alone would not be viable for many practices to survive.

While we share Commissioner Jaffrey's concerns about the "bottleneck" in training new physicians due to the limited number of residency training slots, we disagree that it is the sole reason for access concerns. We believe that the biggest near-term impact on the size of the physician workforce will likely be achieved by improving retention rates and reducing the rate at which already-practicing physicians retire, resign, or reduce their hours. A report by the Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2021 to 2036*, estimates that the shortage of physicians will be affected as much or more by when current physicians retire as by how many new physicians enter the workforce. Many physicians say they will likely leave their practice or reduce their hours following the COVID-19 pandemic. It is important that MedPAC consider patient access to care concerns that arise from both inadequate physician recruitment and retention, as well as growing financial strains on practices and contributors to physician burnout.

Approach One: Update Physician Practice Expenses Based on the Hospital Market Basket Minus Productivity

At the April 2024 meeting, MedPAC discussed two options to increase Medicare physician payment through annual, automatic updates. While we appreciate that both options would update physician payment to account for rising costs to run a medical practice, there are significant drawbacks with the first

option, which would update the practice expense relative value units (PE RVUs) by the increase in the hospital market basket minus productivity. In this scenario, physician and qualified health care professional (QHP) work and professional liability insurance RVUs would not be recognized in the default payment updates. **We agree with many of the Commissioners that the first approach is not viable nor preferable.**

This option would necessitate the creation and use by the Centers for Medicare & Medicaid Services (CMS) of two different conversion factors for each service—one for PE RVUs and another for work and professional liability insurance (PLI) RVUs, which would add more complexity to the Medicare physician payment calculation. Over time, payment rates would become disconnected from the RVUs for the service. Moreover, this option would create disparities in payment based on specialty, with specialties providing high-cost PE services in private practices receiving a higher update than specialties providing lower-cost PE services in private practices and services in ambulatory surgery centers, hospital outpatient departments, or other facilities. In other words, this approach would mean higher updates to specialties such as allergy/immunology, radiation oncology, vascular surgery, interventional radiology, and dermatology, and lower updates to other specialties, including critical care, hospital medicine, and emergency medicine, based on their office-based overhead, such as non-clinical staff salaries, equipment, and supplies. These divergent updates risk worsening access problems for specialties with lower practice expenses, including psychiatrists and internal medicine physicians.

Moreover, updating PE RVUs alone is insufficient. Practice expense is only one component of a multifactorial formula to compensate physicians for the total costs of running a medical practice and caring for Medicare beneficiaries. Payment for physician work—the time, energy, and expertise devoted to treating patients by physicians, nurse practitioners, physician assistants, and other qualified health care professionals—is no less important as it also contributes to the total cost of providing a service and is equally impacted by inflation.

Professional liability insurance is another part of Medicare's physician payment formula that is not addressed via Approach One. We want to bring to your attention alarming data that show the emergence of a so-called "hard" medical liability insurance market in a growing number of states. In a report issued last year, the AMA found that medical liability premiums continue to increase at rates not seen since the early 2000s. In 2019, the proportion of premiums that increased year-to-year almost doubled from what it was in 2018, increasing from 13.7 percent to 26.5 percent. Then, between 2020 and 2022, about 30 percent of premiums went up year-to-year over that period of time. Because of the risk of being sued over the course of a physician's career, and because medical liability insurance is so costly, the liability environment is increasingly becoming another significant cost factor for physician practices, affecting patients' access to care and treatment. Accordingly, in addition to pursuing professional liability reforms, it is important that updates to the professional liability insurance portion of Medicare physician payment keep pace with increasing premium costs.

Finally, and importantly, we question the use of the hospital market basket minus productivity as a proxy for physicians' operating costs. Using the hospital market basket in the MFS could have unintended consequences. As part of its rationale for this approach, the Commission repeated its concerns about the site-of-service differential in Medicare payment for services provided to beneficiaries in physicians' offices compared to hospital outpatient departments (HOPDs). For outpatient services and procedures that can be appropriately provided in both settings, Medicare often pays a higher rate to HOPDs than physician offices. The site-of-service differential stems in part from the absence of permanent, inflation-based updates to Medicare physician payments, not from the use of an inflation-based metric that is specific to physician practices like the MEI.

Furthermore, HOPD payments are updated in full by the hospital market basket and those payments also go toward physician compensation, unlike Approach One, which would only update physicians' practice expenses. **The way to close the site-of-service differential is to recommend Congress update Medicare physician payments, not just their practice expenses, by the full MEI.**

Approach Two: Updating Medicare Physician Payment Rates by MEI

Also discussed at the April 2024 meeting was an option to increase Medicare physician payment by MEI minus one percentage point with a floor of half of MEI. **The AMA agrees that updating Medicare physician payment by MEI is necessary** and has applauded MedPAC's recommendations that Congress increase the 2024 and 2025 Medicare physician payment rates above current law with an inflation-based update tied to the MEI. However, during this time, physician payments have continued to decline. Currently, physicians are absorbing cuts of nearly two percent. The impact of the current payment cuts on several services that are both high-volume and critical to patient health outcomes, including preventive and primary care services, is shown in the table below.

CPT/ HCPCS Code	**Description**	**Estimated CY2023 Allowed Charges** *(using $33.8872 CF and 2023 RVUs)*	**Combined Impact for Jan 1-Mar 8, 2024** *(using $32.7442 CF and 2024 RVUs)*	**Combined Impact for Mar 9-Dec 31, 2024** *(using $33.2875 CF and 2024 RVUs)*	**Estimated CY2024 Allowed Charges** *(using 2024 RVUs and Calendar Day Weighted CFs)*	**Combined Impact of CY2024 Final Rule and Legislation** *(using 2024 RVUs and Calendar Day Weighted CFs)*
99214	Office/Outpatient Visit Established Patient Moderate MDM 30 Min	$ 12,109,705,146	-2.0%	-0.4%	$ 12,029,070,652	**-0.7%**
99233	Subsequent Hospital Inpatient/ Observation Care High MDM 50 Min	$ 3,076,755,140	-3.4%	-1.8%	$ 3,012,524,591	**-2.1%**
66984	Cataract Surgery	$ 789,441,645	-2.5%	-0.9%	$ 780,226,670	**-1.2%**
77067	Screening mammography bilateral	$ 403,619,965	-3.8%	-2.3%	$ 393,333,707	**-2.5%**
17110	Destruction benign lesions, up to 14 lesions	$ 308,996,152	-2.8%	-1.2%	$ 304,504,059	**-1.5%**
59400	Obstetrical care	$ 4,306,191	-1.9%	-0.3%	$ 4,280,261	**-0.6%**

As you can see, these cuts are not sustainable for physicians and their patients and risk jeopardizing access to these critical services, and we commend MedPAC for continuing to consider a Medicare physician payment update that is tied to MEI.

While we strongly support an MEI-based update overall and recognize that MedPAC's specific approach of applying an update of MEI minus one percentage point with a floor of half of MEI is a significant improvement compared to current law, **we are concerned that this option would still allow the gap between the growth in the medical practice costs and physician payment to continue to cumulate and grow over time.** We firmly disagree with MedPAC's claim that MEI minus one percentage point was historically adequate and will sufficiently cover inflation in practice costs and ensure patient access to care into the future. During the last 20 years, the health care industry has changed dramatically. Some of these changes may have resulted from decision makers trying to compensate for the lack of proper Medicare MFS updates. For example, MedPAC discussed the site-of-service payment differential, which has incentivized vertical consolidation. In addition, there are significantly greater administrative demands on physician practices today than in the past 20 years, such as the average $12,800 cost per physician per year to participate in the Merit-based Incentive Payment System (MIPS). These changes challenge the idea that MedPAC should rely on the past as it considers Medicare physician payment updates for the future.

Despite our concerns about a recommendation that Congress update physician payment by less than the full increase in MEI, there are several advantages of Approach Two over Approach One. First, increasing Medicare physician payment by an amount tied to MEI would preserve relativity within the physician payment schedule and update payments evenly across specialties, unlike Approach One which would create winners and losers among specialties.

The AMA also believes MEI is a more accurate inflation-based metric to update physician payment. The MEI, first implemented in 1975, has long served as a measure of practice cost inflation and a mechanism to determine the proportion of payments attributed to physician earnings and practice costs. While we understand it is currently based on data from 2006, the AMA is currently undertaking a comprehensive Physician Practice Information (PPI) Survey, supported by 173 health care organizations, with the primary purpose of providing data to update the MEI and Resource Based Relative Value Scale (RBRVS). The AMA has contracted with Mathematica, an independent research company with extensive experience in survey methods as well as care delivery and finance reform, to conduct this survey. A coalition of QHP organizations is also working with Mathematica to administer a similar study of their respective professions. These physician and QHP surveys will be in the field through June 2024. Summary data will be shared with CMS in early 2025. The AMA has previously briefed MedPAC staff on the PPI survey and would be happy to provide further updates on its current status.

Regarding the Commission's comment on rescaling the RVUs to reflect updated MEI cost data, the AMA has serious concerns with CMS' proposed methodology for reweighting the three components of physician payment—work, PE, and PLI. Specifically, CMS used data from the U.S. Census Bureau's Service Annual Survey as the primary source for the proposed MEI cost-component weights. The changes lead to substantial increases in the weights for many of the key components of physician PE and would greatly reduce the MEI weights for physician work and PLI. If the implementation of the MEI weights is budget neutral, overall physician work payment would be cut by seven percent and PLI payment would be reduced severalfold. These large shifts are principally due to a substantial error in CMS' analysis, which omitted nearly 200,000 facility-based physicians. After correcting for this major omission, the physician work MEI weight would instead increase and PLI would likely experience a much smaller reduction. The AMA was pleased that CMS in the 2024 MFS Final Rule postponed implementation of the

updated MEI weights until after the AMA completes its national study to collect representative data on physician practice expenses.

The last con discussed by MedPAC staff about Approach Two is that additional policies may be needed to address low PE payments for certain services. However, this is not so much a con in the approach but recognition that this lever alone will not be a one-size-fits-all solution to address the payment inequities of the Medicare payment system. Rather than a con, we see this as an advantage due to its simple approach of raising all physician payments by MEI. Therefore, it not only avoids the unintended consequences of Approach One, it would also allow for a combination approach in tandem with targeted policies to ensure adequate payment based on current economic indicators, which is another strong advantage of this approach.

Accordingly, the pros for this option far outweigh the cons discussed at the April 2024 meeting. First, as discussed above, we believe updating Medicare physician payments in total, including work and PLI RVUs, is necessary as all components of the payment formula are affected by inflation, not just practice expenses. Second, as discussed above, the site-of-service differential stems in part from the lack of an annual inflation-based update to Medicare physician payment. As a result, from 2001 to 2024, Medicare physician payment has increased only nine percent, or declined 29 percent when adjusted for inflation in practice costs. By contrast, Medicare hospital pay has increased roughly 70 percent between 2001 and 2023, with average annual increases of 2.5 percent per year for inpatient services and 2.4 percent for outpatient services. Achieving site-neutral payments for outpatient services and procedures will require increases in Medicare physician payment, so that independent practices, which are often the most cost-effective setting, can be sustained and patient choice safeguarded. While both options discussed at the April 2024 meeting would result in substantially greater increases to physician payment than current law, Approach Two would lead to a 12.7 percent estimated cumulative growth in physician payment between 2024 and 2033 while Approach One would increase payments by 11.4 percent. A higher update would go further toward closing the site-of-service differential between physician offices and HOPDs.

2. **Continued Advanced Alternative Payment Model (APM) Incentive Payments are Necessary to Expand APM Development and Physician Participation**

The AMA strongly agrees with the vast majority of Commissioners that Congress should reauthorize crucial incentive payments to increase physician participation in Advanced APMs. Currently, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. While the goal was to provide opportunities for most physicians to transition into APMs, Center for Medicare and Medicaid Innovation (CMMI) models implemented to date often have steep financial risk requirements, lack of funding needed to successfully redesign care delivery, are usually only available in selected regions, and have largely been focused on total cost of care and primary care models.

Unfortunately, many of the APMs to date have been required to demonstrate savings for Medicare within a short timeframe and despite showing signs of progress in terms of improved care outcomes, are often terminated instead of being improved and expanded nationwide. Small practices and those in rural or underserved areas have also disproportionately been left behind in the transition to APMs despite having patient populations that could arguably stand to benefit the most because many lack the capital to finance the upfront costs of transitioning to an APM, including hiring personnel and building technology infrastructure necessary for participation in an APM. The newest Medicare primary care demonstration, called Making Care Primary, has many promising features including a longer 10.5-year contract period,

upfront funding opportunities, and gradual integration with several specialties, but participation is limited to eight states. Thus, there remains no nationwide primary care medical home model in Medicare, so patients are not benefiting from the improvements in preventive care, health care quality, and management of chronic conditions that medical homes can provide depending on where they live.

A failure to integrate specialists into APMs has been another critical shortcoming of models to date. Recently, CMS announced an update on its multi-pronged strategy to involve specialists in APMs, including enhanced data transparency, maintaining momentum on episode and condition-specific models, and creating financial incentives for specialists to engage in primary care and population health models. The agency also previously announced an ambitious goal to have 100 percent of all Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030.

At this critical juncture in the transition to value-based payment models, it is important to continue building on existing progress. Continuing the APM incentive payment will encourage continued adoption of APMs, including carrying this momentum forward into specialties, geographic areas, and patient communities that have not yet had the opportunity to participate in APMs. The AMA appreciates Congress recently extending the Advanced APM bonus and will continue to advocate for a longer-term extension to bring more physicians, practices, and most importantly patients, into value-based care models.

In addition to the need to extend the APM bonus, it is critical that the sharp increases in the threshold percentages of APM participation for physicians to qualify for the APM incentive payments under MACRA be addressed as most APM participants cannot attain the higher thresholds.

A great source of frustration to the physician community is that, despite the many stakeholder-developed APMs recommended by the Physician-Focused Payment Models Technical Advisory Committee (PTAC) for testing or implementation, no Medicare APMs have been adopted from the PTAC proposals or developed by CMMI, particularly those intended to help specialists improve care for patients with chronic diseases like rheumatoid arthritis, heart failure, chronic obstructive pulmonary disease, or inflammatory bowel disease, or patients who would benefit from innovations in surgical care. Instead of keeping patients healthier and preventing hospitalizations, CMMI-developed APMs have largely focused on services provided to patients after they have already been admitted to the hospital or begun treatment such as chemotherapy. As a consequence, Medicare patients, especially those outside of the hospital setting, are missing out on the benefits of APMs, including more timely and accurate diagnosis, improved patient-physician shared decision making about treatment plans, preoperative rehabilitation, as well as savings from enhanced care coordination and smarter choices about when to use biologics and other therapies.

It is clear that significant changes are needed to realize the robust pathway to APMs that Congress envisioned. This is why the AMA and numerous other physician organizations support the Value in Health Care (VALUE) Act, H.R. 5013, which is bipartisan legislation that would:

- Reauthorize incentive payments to increase physician participation in Advanced APMs.
- Make participation thresholds for earning the incentive payments more flexible and realistic, thus preventing abrupt increases scheduled to take effect in 2025.

3. Additional Context Needed for Discussion of MFS and Coding Changes

At the April 2024 meeting, the Commission introduced several other policy considerations, including recommending reforming or unbundling all 10-day and 90-day global surgical services. Any discussion of this policy option warrants greater background on bundled codes in general and the global surgical codes in particular. Codes with assigned global periods of 10 or 90 days have multiple services bundled into one payment amount. These services include: all pre-operative work performed within 24 hours of the surgery; the surgery itself; and all post-operative work on the day of the procedure and for 10 or 90 days following the procedure, including hospital and office visits. In addition, there are maternity codes (MMM global) that describe the bundled services in obstetrical care codes. End Stage Renal Disease monthly codes and Radiation Treatment Management are two commonly performed services that are valued with a bundle of services. In summary, bundled services are common in the RBRVS payment system.

In the 2015 MFS Final Rule, CMS finalized a plan to transition all 10-day and 90-day global codes to 0-day global codes. As support for its plan, CMS referenced challenges it has experienced in obtaining available data to verify the number, level, and relative cost of post-operative visits included in global packages. CMS also expressed concern that 10-day and 90-day global packages may, in some cases, no longer accurately reflect the post-operative care provided to the typical patient. However, Congress passed MACRA, which prohibits the implementation of the above stated CMS policy. In place of the transition, MACRA required CMS to develop a process to gather information needed to value surgical services from a representative sample of physicians.

In the 2020 MFS Proposed Rule, CMS released three RAND reports regarding global surgery based on the data collection effort. The AMA found extensive flaws in the RAND analyses, which are detailed in our comment letter. For instance, the first report relied on claims-based reporting of post-operative visits using CPT code 99024, but participation was limited and intermittent and CMS and RAND researchers expressed difficulty in matching up procedures to CPT code 99024. Moreover, RAND inappropriately assumed that each of the 54 percent of physicians who did not participate did not provide any office visits in any surgery's global period rather than assuming they were simply unaware of the study or unable to participate.

The second RAND report, which was based on a survey limited to three high-volume services, found average visits were somewhat shorter than anticipated for cataract surgery and hip arthroplasty and longer for complex wound repair. However, RAND misinterpreted the findings of their survey data as they compared only the survey physician time "on the day of the visit" to the CMS physician time file, where the pre-service and post-service time of Evaluation and Management (E/M) services is not specific to the date of the encounter. RAND categorized nurse practitioner and physician assistant survey data as "staff time" and incorrectly observed that "…such staff time would be considered as part of the PE in the RVS Update Committee (RUC) process and not contribute to the physician time component nor to the level of the visit." While this is the case for work performed by clinical staff, this is never the case for qualified health plans who can separately report Medicare services. Unfortunately, CMS relied on the flawed RAND reports to pay surgeons at a different rate from other physicians for post-operative office visits and distorted the relativity within the established RBRVS.

Some Commissioners seemed to indicate that unbundling the global surgical services would result in savings to the Medicare program and beneficiaries. We question this hypothesis. The level of post-operative E/M visits considered bundled into the global package varies widely from separately reported E/M visits. The median E/M visit bundled into a global surgical code is 99212, whereas the median

separately reported E/M visit is 99214 (see following chart).

CPT Code	2022 Medicare Utilization (Separately Reported Visits)	Separately Reported Utilization Percentage	2022 Medicare Utilization (Bundled Visits in Surgical Global Period)	Surgical Global Bundled Utilization Percentage
99212	8,350,126	4.4%	24,452,613	56.3%
99213	73,675,393	38.4%	18,340,512	42.2%
99214	98,487,922	51.3%	618,671	1.4%
99215	11,327,040	5.9%	22,788	0.1%

Moreover, as mentioned above, CMS declined to apply the RUC office visit recommendations, which increased the valuation of standalone E/M office visit codes, to the E/M office visit component of the 10-day and 90-day global codes. If unbundled, the E/M visits during the post-operative period would become payable at the higher standalone rate. Rather than unbundling these services, **the AMA continues to recommend that CMS indicate specific codes which it believes are potentially misvalued so that the RUC may address individual services without penalizing all surgeons and all services with a global period.**

In addition, there has been some discussion about the burdens of coding certain services within the MFS, particularly services provided by primary care physicians. We remind the Commission that the impetus behind the E/M coding overhaul, which began with the office and outpatient code family in 2021 and expanded to other code families in 2023, was to reduce documentation burden or "note bloat" across all specialties and sites of service. Burden relief was accomplished through several coding guidelines and CMS policy changes, including:

- CMS eliminated the requirement that physicians re-record elements of history and physical exams when there is evidence that the information has been reviewed and updated.
- The updated guidelines simplified code selection criteria and made them more clinically relevant and intuitive by allowing selection based on time or medical decision-making.
- The updated guidelines created consistency across payers by adding detail within the CPT E/M guidelines and aligning Medicare and CPT requirements.

These changes were embraced by the physician community, including the American Academy of Family Physicians and American College of Physicians, as reducing unnecessary documentation burden. For example, the new framework includes CPT code descriptor times, revises interpretive guidelines for levels of medical decision-making, and permits choice of medical decision-making or time to select code level.

4. The Meritless Incentive Payment System is Plagued by Problems that Warrant Urgent Congressional Action

The AMA agrees with MedPAC that MIPS is fundamentally flawed. In its current form, MIPS is a repackaging of broken legacy reporting programs. CMS will often highlight its efforts to change the program via the new MIPS Value Pathways (MVPs), but MVPs retain the same core rules and requirements of MIPS, despite physicians' recommendations for improvements and early participation in

the development of MVPs. Worse, there is a growing body of evidence suggesting that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients. Moreover, physicians are largely stuck in MIPS as there are far fewer APM opportunities than anticipated when MACRA was passed in 2015.

Therefore, the AMA is strongly recommending that Congress make three key changes to MIPS to help remedy these problems:

1. Mitigate steep MIPS penalties following the COVID-19 pandemic that disproportionately harm small, rural, independent practices and practices that care for the underserved and allow practices to revitalize quality improvement infrastructures;
2. Hold CMS accountable for timely and actionable MIPS and claims data; and
3. Make MIPS more clinically relevant while reducing burden.

The AMA strongly believes that each of these policy changes is essential to improve the clinical relevance of MIPS, provide a bridge to transition to APMs, and promote the intended goals of MACRA to leverage health information technology, improve quality, and reduce Medicare costs all while reducing burden on physician practices. The AMA is happy to brief MedPAC staff on our recommendations to transform MIPS.

The AMA appreciates MedPAC's attention to opportunities to correct the current deficiencies of the current Medicare physician payment system and thanks the Commission for its consideration of our input on these topics. If you have any questions regarding this letter, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD