

Surgical Coalition’s Plan for Reforming the Medicare Physician Payment System

The Centers for Medicare & Medicaid Services (CMS) continues to put forth annual regulations that exacerbate the underlying problems within the broken Medicare physician payment system. Furthermore, these policies negatively impact the ability of physician practices to invest in quality improvement efforts to benefit Medicare patients or transition to alternative payment models when appropriate. And importantly, the Medicare Physician Fee Schedule is often the benchmark for determining payment rates for Medicaid and other payers. Thus, Medicare payment cuts have a cascading effect across all payers, challenging physician practices’ ability to cover the cost of taking care of their patients.

While Congress considers long-term reforms to physician payment, it must exercise its oversight authority over Medicare payment policy to ensure a stable environment that allows multiple physician practice models — independent private practice or hospital/hospital system employment — to thrive. Failure to do so will contribute to the ongoing, costly consolidations of the health care delivery system, hinder patient access to the physician of their choice, and hamper efforts to move toward safe, accountable, high-quality care.

Current legislative and regulatory policies impede efforts to improve the quality and value of care provided in all practice settings and geographic areas, and they create adverse incentives for volume. For example, focusing on payment program requirements that may have little to do with direct patient care takes time and resources from activities that could have a more meaningful impact. Similarly, artificially holding reimbursements below the rate of inflation may mean that a practice needs to squeeze in more patients and charges to keep their practice afloat and their staff employed. A shift in policy direction is necessary to provide Medicare patients with high-quality, patient-centered, value-based care, which is the ultimate goal.

To do this, Congress and the Administration must:

1. **Stop all Medicare physician payment cuts scheduled for calendar year 2024.** Ongoing cuts to the Medicare physician fee schedule make it difficult for physicians to invest resources in value-based care initiatives.
2. **Establish an annual Medicare Economic Index (MEI) update.** An annual update to the Medicare physician fee schedule comparable to that in other payment programs (e.g., hospitals) starting with calendar year 2024 will help ensure that payments keep pace with medical cost inflation.

Updates for Selected Medicare Payment Programs

	2022	2023
Physician Fee Schedule	-3.7%	-2%
Hospital Inpatient (IPPS)	2.5%	4.3%
Hospital Outpatient (OPPS/ASC)	2.0%	3.8%
Skilled Nursing Facility	1.2%	2.7%
Home Health	3.2%	0.7%

3. **Eliminate certain budget neutrality requirements.** Medicare’s budget neutrality requirement — unique to the physician payment program — has been a key driver of the broken payment system. It requires CMS to implement across-the-board cuts if changes to the Medicare physician fee schedule cause expenditures to exceed \$20 million annually. This trigger amount has remained the same since its implementation in 1992. At a minimum, 42 USC 1395w-4 (c)(2)(B)(ii) should be amended to increase the current \$20 million budget neutrality adjustment trigger to \$100 million and indexed to adjust for inflation moving forward.

- 4. Halt implementation of the G2211 add-on code.** This new CMS-created payment code was proposed as a budget-neutral way to increase payments to primary care and other office-based physician specialties to account for CMS' proposal at the time to collapse the higher level complexity of primary care visits. The rationale for creating the G2211 add-on code is no longer valid because CMS ultimately implemented changes in 2021 to the office visit codes that incorporated complex visits, thus substantially increasing payment for office visit codes. Primary care and other physicians can now bill a higher-level evaluation and management (E/M) office visit code, obviating the need for the G2211 code — which, if implemented, will result in a 3% across-the-board cut to the conversion factor.
- 5. Appropriately value the global codes.** Since 1997, CMS increased the E/M portion of the global code values to reflect increases in the stand-alone E/M codes each time these office visit codes were adjusted. In 2021, CMS did not apply the adjusted values to the 10- and 90-day global surgical codes. Global surgery payments must be modified to include the current stand-alone E/M payment levels as adjusted in 2021. Furthermore, CMS should refrain from making any other changes to the 10- and 90-day global codes that would have a negative effect on patient access to surgical care and/or are not based on reliable and accurate data collection.
- 6. Avoid payment cuts due to MEI rebasing.** Rebasing the MEI cost weights may lead to steep Medicare payment cuts for some surgical care. Any rebasing should not rely on flawed data and should appropriately represent the cost share of physician work, practice expense and professional liability insurance.
- 7. Keep Medicare savings in the Medicare program.** Invest savings generated by any new Medicare payment policy (e.g., site neutrality) to offset the cost of improving the Medicare physician payment system.

These are only short-term measures that must be enacted by the current Congress and Administration, as we work together in the next few years toward a more sensible system of physician payment that accounts for quality and value.

Signed:

American College of Surgeons

American Academy of Facial Plastic and Reconstructive Surgery

American Academy of Ophthalmology

American Association of Neurological Surgeons

American Association of Orthopaedic Surgeons

American College of Obstetricians and Gynecologists

American Orthopaedic Foot & Ankle Society

American Society for Metabolic and Bariatric Surgery

American Society for Surgery of the Hand Professional Organization

American Society of Anesthesiologists

American Society of Breast Surgeons

American Society of Cataract and Refractive Surgery

American Society of Colon & Rectal Surgeons

American Society of Plastic Surgeons

American Society of Retina Specialists

American Urogynecologic Society

American Urological Association

Congress of Neurological Surgeons

Society for Vascular Surgery

The Society of Thoracic Surgeons