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Advancing Health in America

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April 4, 2025

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Dear Chairman Chernew:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to share our comments regarding the Medicare Payment Advisory Commission's (MedPAC's) March meeting recommendations on physician fee schedule payments.

We appreciate the thoughtful discussions the Commission has had over the past three years regarding physician payments. This is a challenging issue, but one that is critical to address to ensure beneficiary access to quality primary care and specialty providers. Thus, given recent discussions at the March meeting, we urge MedPAC to:

- **Recommend a full inflationary update to physician payment instead of an update based on a portion of the Medicare Economic Index (MEI).**
- **Remove recommendations to update relative value unit (RVU) calculations.**
- **Reiterate its concerns about expiring alternative payment model (APM) incentive payments.**

Detailed feedback on these recommendations is below.

PHYSICIAN FEE SCHEDULE AND MEI RECOMMENDATION

In the March meeting, commissioners reviewed a recommendation for Congress to replace the current law updates to the physician fee schedule with an annual update based on a portion of the growth in the MEI (e.g., MEI minus 1%). **We value the commission's continued focus on addressing the woeful inadequacy of physician payment. However, we are concerned that such an annual update is not sufficient to make up for the existing shortcomings in physician reimbursement.** Addressing this issue is of utmost importance to ensure the continued provision of vital care to Medicare beneficiaries. As we have commented previously, updates to the physician

fee schedule conversion factor have not kept pace with inflation.[1,2] Medicare's conversion factor, which determines physician payment, declined by over 13% in real dollars from 2001 to 2024. The actual reduction when accounting for inflation is a staggering 29%. Continued decrements are unsustainable, particularly in light of the physician shortages the country is facing. **Therefore, we continue to urge MedPAC to recommend a higher update to physician reimbursement that more fully accounts for inflation.**

ACCURACY OF RELATIVE PAYMENT RATES RECOMMENDATION

MedPAC also reviewed a recommendation for Congress to direct the secretary to improve the accuracy of relative payment rates by 1) updating cost data regularly and 2) ensuring that the methodology used to determine payment rates for different services reflects the settings in which clinicians practice medicine. **We are encouraged that MedPAC is evaluating strategies to improve the accuracy of RVU calculations. However, we are concerned that the policy recommendations presented do not address the underlying issues with payment and may inappropriately penalize facility-based providers.**

For example, the recommendation to update cost data regularly (which would yield a rebased and revised MEI) does not address the overall issue of inadequate payment per RVU. Additionally, any updates to RVUs would cause a redistribution of payments based on physicians' geography and specialty. **As such, we urge MedPAC to further evaluate the potential redistributive effects of cost data updates, especially in light of physician shortages and pervasive underpayments.**

Moreover, the recommendation to revise the RVU methodology based on clinician setting could inappropriately penalize facility-based providers and potentially exacerbate the consolidation of physician practices by non-traditional providers. Unsustainable reimbursement has driven many physicians to pursue employment models that provide stable payment through salaries and enable physicians to focus on direct patient care. Cutting payment to facility-based providers would not solve these issues in physician reimbursement; rather, it would lead to decreases in access since hospitals may no longer be able to absorb additional reductions in reimbursement without cutting services. Indeed, hospitals already must subsidize inadequate payment to preserve access to care in communities, with recent data indicating that subsidies per physician have increased 5% in the last three years to over $306,000 (see figure 1 below).[3]

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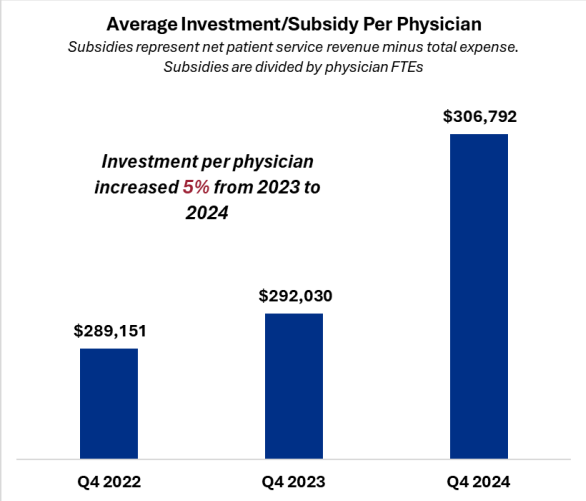
[1] https://www.aha.org/lettercomment/2024-12-09-aha-comments-medpac-re-physician-fee-schedule-payments-apm-incentives-and-medicare-advantage-network
[2] https://www.aha.org/2025-01-10-aha-comments-advance-medpac-january-2025-meeting
[3] https://www.kaufmanhall.com/insights/research-report/physician-flash-report-q4-2024-metrics

Figure 1. Average Subsidy Per Physician



Furthermore, decrements to facility-based providers will create a greater incentive for physicians to seek out employment from non-traditional providers. Of the physician acquisitions that occurred over the last 5 years, the majority have been acquired by private equity companies, other physician groups and health insurers.[4] In fact, of the physician acquisition deals from 2019 to 2023, private equity-backed startups acquired 65% of physician practices, and insurers acquired 14% of practices in that same timeframe. This is compared to hospitals and health systems that only accounted for 6% of physician acquisition acquirers. **Therefore, we oppose policy options to revise RVU methodology in ways that would decrease payment to facility-based providers.**

ALTERNATIVE PAYMENT MODEL INCENTIVES

Finally, we urge MedPAC to reiterate its concerns about the pending expiration of advanced APM incentive payments. While it has previously discussed incentives to support transition to value-based care, the absence of formal policy recommendations related to this issue may be misconstrued to mean that incentives are no longer needed. These payments continue to support providers' transitions to value-based payment models and support the provision of non-fee-for-service programs like meal delivery programs, transportation services and care coordinators that promote population health.

[4] https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA's director of payment policy, at swu@aha.org or 202-626-2963.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Paul Masi, M.P.P.
MedPAC Commissioners