Stabilize the Medicare Physician Payment System

Senate: Provide an inflationary update to stabilize the Medicare physician payment system and increase the Medicare Physician Fee Schedule budget neutrality threshold to $100 million.

House: Co-sponsor the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474) and increase the PFS budget neutrality threshold to $100 million.

For more than 20 years, Medicare payments have been under pressure from the Centers for Medicare & Medicaid Services (CMS) anti-inflationary payment policies. While physician services represent a relatively modest portion of overall federal health care spending, they are perennial targets for cuts when policymakers seek to tackle affordability. Since 2001, physicians have seen their Medicare payments decrease by nearly 30 percent, including the most recent cut in 2024. These arbitrary cuts fail to incentivize quality or care coordination.

The Medicare Physician Fee Schedule (PFS) suffers from multiple shortcomings. It is unique in its lack of a meaningful mechanism to account for inflation and is currently in a multi-year window through 2026 where any positive updates to physician payment must be directly legislated. Furthermore, the system remains constrained by a budget-neutral financing system, which means even modest changes in spending can result in across the board cuts to all services.

Updates to the Conversion Factor (CF) have failed to keep up with inflation and in recent years have been negative, with additional cuts to Medicare physician payments expected in 2025. Under current law, and assuming no additional cuts result from budget neutrality or other policy decisions, it would take decades for the CF to return to the same amount it was in the year 2000. Over that same period, inflation will have significantly eroded the value of payments. An annual update to the PFS comparable to that in other payment programs will help ensure that payments keep pace with medical cost inflation. The combination of high inflation and a lack of updates to account for increased expenses means that it costs more to deliver care while payments are declining. Without meaningful changes to address the challenges of a budget-neutral payment system or providing adjustments to account for the increased cost of staff, office space, and other resources, surgeons will find it increasingly difficult to continue to improve care and outcomes.

The negative impact of the lack of inflationary adjustments is further compounded by the overly strict nature of the budget neutrality trigger in the PFS. Some of the upcoming cuts are a direct result of the budget neutrality requirement – unique to the PFS – which results in across-the-board cuts for any changes to the PFS expected to increase expenditures by as little as $20 million annually. This trigger amount has remained the same since its implementation in 1992 and must, at a minimum, be increased and indexed to adjust for inflation moving forward.

Congressional Action

While Congress has taken action to address some of these fiscal challenges by mitigating part of the recent PFS cuts, Medicare payment continues to decline year after year. The recent 1.68 percent adjustment falls short of the 3.37 percent cut that went into effect in early 2024. These yearly compounding cuts, combined with a broad lack of viable alternative payment models for surgeons, demonstrate that the Medicare payment system is broken. These systemic issues will continue to hinder surgeons' ability to undertake important quality improvement initiatives or make investments needed to move toward value-based care.

Stakeholders and congressional leaders agree that these yearly cuts are not sustainable. In their March 2023 report to Congress, the Medicare Payment Advisory Commission recognized the need to account for inflation, incorporating a Medicare Economic Index (MEI) based update into its recommendation for 2024. Additionally, Representatives Raul Ruiz, MD (D-CA-25), Larry Bucshon, MD (R-IN-08), Ami Bera, MD (D-CA-06), and Mariannette Miller-Meeks, MD (R-IA-01) introduced the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474) to provide an update to the PFS based on the MEI, allowing physician reimbursement to be adjusted for inflation in line with other Medicare providers such as hospitals, nursing homes, and home health providers.

CONGRESSIONAL ASK

Senate: Provide an inflationary update to stabilize the Medicare physician payment system and increase the PFS budget neutrality threshold to $100 million.

House: Co-sponsor the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474) and increase the PFS budget neutrality threshold to $100 million.

End Costly Insurer Fees

Senate and House: Co-sponsor the *No Fees for EFTs Act* (S. 3805/H.R. 6487).

Under current law, health plans are required to offer medical practices the option to receive reimbursements electronically. However, some insurers or their vendors impose fees on health care providers of up to five percent of the claim payment for these electronic fund transfers (EFTs). Practices are forced to accept these fees or incur the additional unnecessary administrative burden of processing checks through the mail.

A 2023 survey by the Medical Group Management Association found that for most medical practices, EFTs account for 75 percent or more of their annual revenue, resulting in up to $1,000,000 in fees annually. These fees represent yet another financial and administrative burden on physicians already struggling due to increased practice expenses, high inflation, and falling payment for their services.

Congressional Action

The *No Fees for EFTs Act* (S. 3805/H.R. 6487), introduced by Senators Bill Cassidy, MD (R-LA) and Maria Cantwell (D-WA) as well as Representatives Greg Murphy, MD (R-NC-03), Derek Kilmer (D-WA-06), Morgan Griffith (R-VA-09), Ami Bera, MD (D-CA-06), Mariannette Miller-Meeks, MD (R-IA-01), and Kim Schrier, MD (D-WA-08), would prohibit health plans, or an entity completing a financial transaction on behalf of the plan, from imposing any charge, fee, or other payment on a health care provider for EFTs and health care payment and remittance advice transactions made on or after January 1, 2024. Importantly, this ban would apply to both public and private health plans, ensuring all health care providers are protected from these onerous charges.

CONGRESSIONAL ASK

Senate and House: Co-sponsor the *No Fees for EFTs Act* (S. 3805/H.R. 6487).

Support the Surgical Workforce and Patient Access to Care

Senate and House: Co-sponsor the *Ensuring Access to General Surgery Act* (S. 1140/H.R. 1781), the *Resident Education Deferred Interest (REDI) Act* (S. 704/ H.R. 1202), the *Specialty Physicians Advancing Rural Care (SPARC) Act* (S. 705/H.R. 2761), and the *Workforce Mobility Act* (S. 220/H.R. 731).

Surgery is an essential element in the care of a community or region. In areas with an insufficient surgical workforce, patients in need of care must travel to a place with surgical capabilities, leading to delays in care and potentially suboptimal outcomes. Unlike other key providers of the community-based health care system, general surgeons do not have a formal workforce shortage area designation. A 2020 report conducted by the Health Resources and Services Administration (HRSA) found that there is a serious maldistribution of general surgeons in the US, with supply only able to meet approximately 69 percent of demand in rural areas and 75 percent of demand in suburban areas. Likewise, a 2021 report from the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Rural Health Research Center (RHRC) found that between 2001 and 2019, rural areas experienced a 29.1 percent decrease in the supply of general surgeons, and in 2019, 60.1 percent of non-metropolitan counties had no active general surgeon at all.

Optimal quality, the centerpiece of the American College of Surgeons' mission, is not achievable without optimal access. It is essential that policymakers understand where surgical shortages exist and take steps to incentivize surgical practice in those areas to ensure all patients have access to the full spectrum of high-quality health care services.

Congressional Action

Ensuring Access to General Surgery

The *Ensuring Access to General Surgery Act* (S. 1140/H.R. 1781), introduced by Senators Brian Schatz (D-HI) and John Barrasso, MD (R-WY) and Representatives Larry Bucshon, MD (R-IN-08), Ami Bera, MD (D-CA-06), John Joyce, MD (R-PA-13), and Scott Peters (D-CA-50), would direct HRSA to study and define general surgery workforce shortage areas and collect data on the adequacy of access to surgical services, as well as specifically grant the agency authority to designate general surgery shortage areas. Determining what constitutes a surgical shortage and designating areas where patients lack access to surgical services will provide HRSA with a valuable new tool for increasing patient access to care.

Addressing Student Loan Debt

The high cost of medical education contributes to physician shortages. Physicians often accumulate immense student debt during their education and then must undertake several years of residency training with low pay, during which time their student loans accrue significant interest. This financial burden poses a barrier for students wishing to pursue certain specialties, practice in underserved areas, or even enter the health care profession at all. The *REDI Act* (S. 704/H.R. 1202), introduced by Senators Jacky Rosen (D-NV) and John Boozman, OD (R-AR)

and Representatives Brian Babin, DDS (R-TX-36) and Chrissy Houlahan (D-PA-06), would allow borrowers in medical or dental internships or residency programs to defer student loan payments without interest until the completion of their programs. The *SPARC Act* (S. 705/H.R. 2761), introduced by Senators Rosen and Roger Wicker (R-MS) and Representatives Joyce and Deborah Ross (D-NC-02), would establish a new loan repayment program allowing specialty physicians who agree to practice in a rural area for six years to have up to $250,000 of their student loans forgiven. These bills will alleviate some of the financial burden of medical education and help address ongoing health care provider shortages to ensure patients can access the care they need.

Banning Non-Compete Agreements

Many employed surgeons are subject to contractual terms which include a non-compete agreement enforceable upon their voluntary separation or involuntary dismissal from employment, with or without cause. Studies have found that non-competes are often used even when they are illegal or unenforceable with a chilling effect on employee movement. A typical non-compete would bar physicians from practicing for a prescribed period of time within a defined geographic area or specific mile radius of their current employer. The *Workforce Mobility Act* (S. 220/H.R. 731), introduced by Senators Chris Murphy (D-CT), Todd Young (R-IN), Tim Kaine (D-VA), and Kevin Cramer (R-ND) and Representatives Peters and Mike Gallagher (R-WI-08), would prohibit employer non-compete agreements under federal law, with limited exceptions, such as the dissolution of a partnership or sale of a business. This legislation would free physicians from non-competes, providing them with an option to work for a competitor, start a private practice, or even practice in an underserved area, rather than be forced to move hundreds of miles or forgo a professional opportunity.

CONGRESSIONAL ASK

Senate and House: Co-sponsor the *Ensuring Access to General Surgery Act* (S. 1140/H.R. 1781), the *REDI Act* (S. 704/H.R. 1202), the *SPARC Act* (S. 705/ H.R. 2761), and the *Workforce Mobility Act* (S. 220/H.R. 731).

Increase Access to Cancer Screening

Senate: Co-sponsor the *Colorectal Cancer Payment Fairness Act* (S. 1894).

House: Co-sponsor the *Colorectal Cancer Payment Fairness Act* (H.R. 3382) and the *Find it Early Act* (H.R. 3086).

The American College of Surgeons (ACS) is dedicated to improving the survival and quality of life for patients with cancer by providing standards, tools, resources, and data that encourage prevention and early detection, as well as enable cancer programs to deliver comprehensive, high-quality, multidisciplinary, evidence-based, patient-centered care. Central to this mission is robust access to cancer screenings. Patients missed an estimated 9.4 million cancer screening tests across the US in 2020 alone, and the National Cancer Institute (NCI) projects that there may be 10,000 additional cancer deaths from breast and colorectal cancers due to screening that went missed during the COVID-19 pandemic. In addition, research evaluating data from the ACS National Cancer Database found a 15-20 percent decrease in newly diagnosed breast cancer cases reported to ACS Commission on Cancer sites in 2020 compared to 2019, likely due to screening restrictions that occurred in the early months of the pandemic as well as the fear of exposure that may have caused some patients to delay care for breast cancer symptoms. Early detection of cancer can significantly improve patient outcomes, and immediate and continual attention to screening access is critical to make up this lost ground.

Congressional Action

Improving Access to Colorectal Cancer Screening

The *Colorectal Cancer Payment Fairness Act* (S. 1894/H.R. 3382), introduced by Senator Cory Booker (D-NJ) and Representatives Donald Payne (D-NJ-10) and Brian Fitzpatrick (R-PA-01), would build on the previously enacted *Removing Barriers to Colorectal Cancer Screening Act* and require Medicare to offer complete coverage for colorectal cancer treatments patients receive during routine cancer screenings beginning in 2023. The *Removing Barriers to Colorectal Cancer Screening Act,* which was signed into law in 2020, extended Medicare coverage for the removal of polyps found during colorectal cancer screenings, but phases in the change through 2030. The *Colorectal Cancer Payment Fairness Act* will ensure full coverage for these procedures sooner, removing this financial barrier and helping to increase screening rates and reduce the incidence of colorectal cancer.

Improving Access to Breast Cancer Screening

The *Find it Early Act* (H.R. 3086), introduced by Representatives Rosa DeLauro (D-CT-03) and Fitzpatrick, would require health insurance plans to cover screening and diagnostic breast imaging, including mammograms, ultrasounds and breast ultrasounds, and MRIs with no cost-sharing for patients. While most public and private insurance plans cover mammograms, many do not offer coverage for additional types of screening that may be needed for patients with dense breasts,

certain family histories of disease, or other reasons. The result is that many patients may forgo these tests and risk later stage diagnosis. A delay can have serious consequences. Breast cancer found at an early stage has a five-year survival rate of 99 percent, whereas breast cancer found at a later stage has five-year survival rate of less than 30 percent. The *Find it Early Act* will help increase access to breast cancer screening and reduce preventable deaths.

CONGRESSIONAL ASK

Senate: Co-sponsor the *Colorectal Cancer Payment Fairness Act* (S. 1894).

House: Co-sponsor the *Colorectal Cancer Payment Fairness Act* (H.R. 3382) and the *Find it Early Act* (H.R. 3086).

Reauthorize Critical Trauma Programs

Senate: Urgently pass a five-year reauthorization of the *Pandemic All-Hazards Preparedness Act* and the *Emergency Medical Services for Children Act*.

House: Urgently pass a five-year reauthorization of the *Pandemic All-Hazards Preparedness Act.*

As a leader in setting standards for trauma care, The American College of Surgeons (ACS) knows that trauma systems are not only responsible for day-to-day emergency and trauma care, but also scale up to respond to public health emergencies that cause regions to experience a surge in capacity. Moreover, trauma systems serve as critical infrastructure for disaster and emergency response. Because of this, the ACS strongly supports reauthorization of two critically important trauma programs: the *Pandemic All-Hazards Preparedness Act* (PAHPA) and the *Emergency Medical Services for Children Act* (EMSC).

Congressional Action

Reauthorize PAHPA

PAHPA was enacted to improve the nation's response to public health and medical emergencies. PAHPA has been instrumental in coordinating federal efforts to enhance our ability to respond effectively to public health emergencies, ensuring that we are adequately prepared to protect the health and safety of our citizens. The important programs included in PAHPA expired on September 30, 2023. Legislation to reauthorize PAHPA has been introduced in Congress. In the U.S. Senate, the *Pandemic and All-Hazards Preparedness and Response Act* (S. 2333) was introduced by Senators Bob Casey (D-PA), Mitt Romney (R-UT), Bernie Sanders (I-VT) and Bill Cassidy, MD (R-LA). There are two bills to reauthorize PAHPA in the U.S. House of Representatives introduced by Representative Richard Hudson (R-NC-09): The *Preparing for All Hazards and Pathogens Reauthorization Act* (H.R. 4421) and the *Preparedness and Response Reauthorization Act* (H.R. 4420).

The ACS urges Congress to swiftly reauthorize PAHPA for five years with the following priorities:

- **Section 104 of S. 2333 - Improving medical readiness and response capabilities:** This section **reauthorizes the Hospital Preparedness Program (HPP)** and improves coordination and surge capacity of regional medical operations within and among health care coalitions. The language also requires eligible entities to establish and maintain or leverage existing capabilities to enable coordination of regional medical operations within a coalition and between multiple coalitions in close geographic proximity. Maintaining this language in the final bill is critical because it sets a framework for stronger coordination of regional response in an emergency by driving the HPP from solely planning for catastrophic events to having an active role in managing the day-to-day coordination for the care of patients. **Because this language does not authorize additional funding to carry out this work, Congress can greatly strengthen**

coordination and improve access to timely care for patients without spending any additional money.

- **Section 608 of S. 2333/Section 202 of H.R. 4421 - Military and Civilian Partnership for Trauma Readiness:** *The MISSION ZERO Act* was enacted as part of PAHPA in 2019, establishing the Military and Civilian Partnership for the Trauma Readiness Grant program to offset the administrative costs of embedding military trauma professionals in civilian trauma centers. These military-civilian partnerships allow military trauma care teams to gain exposure to treating critically injured patients and increase readiness for when these units are deployed, further advancing trauma care, and providing greater patient access. The grant program is managed through the Administration for Strategic Preparedness and Response. **The ACS urges reauthorization of this important program at the same level of $11.5 million.**

- **Section 204 of S. 2333 - Pilot Program for Public Health Data Availability:** Large-scale events pose numerous challenges for health systems, including fragmented command structure; lack of effective communication between agencies, clinicians, and facilities; inadequate and fragmented data concerning patient location and condition; limited or absent medical surge capability; limited integration of public health with acute private and public health sector care; inadequate integration between local and federal emergency management systems; and lack of ability to coordinate and track patient movement. **The ACS recommends the final bill include this provision,** which would establish a pilot program for state and regional public health situational awareness activities and improve coordination within the Department of Health and Human Services so that deidentified, aggregated data on potentially catastrophic infectious disease outbreaks can be made publicly available in near real-time.

Reauthorize EMSC for Five Years

Approximately thirty million children will visit the emergency department this year, and emergencies involving children can occur anytime, anywhere. As the only federal program dedicated to improving emergency care for children, EMSC has brought vital attention and resources to this important population. Through EMSC, all states and territories have received state partnership grants to expand and improve their capacity to reduce and respond to emergencies. EMSC funding is used to equip hospitals and ambulances with the tools they need to treat pediatric emergencies, provide pediatric training to paramedics and first responders, and improve the systems that allow for efficient, effective pediatric emergency medical care. Established in 2016, the EMSC Innovation and Improvement Center (EIIC) is working to accelerate improvements in the quality of care and outcomes for children who need urgent or emergency care through an infrastructure that ensures routine, integrated coordination of quality improvement activities. Through the EIIC, EMSC works with numerous national organizations, including the ACS Committee on Trauma, and federal partners to identify and address issues affecting the emergency care of children.

Bipartisan legislation to reauthorize the EMSC program for five years, the *Emergency Medical Services for Children Reauthorization Act* (H.R. 6960), passed the U.S. House of Representatives in May 2024. Companion legislation (S. 3765) has been introduced in the U.S. Senate by Bob Casey (D-PA) and Ted Budd (R-NC).

CONGRESSIONAL ASK

Senate: Pass the *Pandemic and All-Hazards Preparedness and Response Act* (S. 2333) and the *Emergency Medical Services for Children Reauthorization Act* (S. 3765) to reauthorize PAHPA and EMSC.

House: Pass the *Preparing for All Hazards and Pathogens Reauthorization Ac*t (H.R. 4421) and the *Preparedness and Response Reauthorization Act* (H.R. 4420) to reauthorize PAHPA.

Support $10 Million for Neglected Surgical Conditions

Senate and House: Include $10 million for Neglected Surgical Conditions within the State, Foreign Operations, and Related Programs Appropriations Report for Fiscal Year (FY) 2025.

Each year, global deaths from conditions requiring surgical care far exceed those from HIV/AIDS, tuberculosis, and malaria – combined. However, the burden of conditions requiring surgical intervention continues to be neglected as a public health strategy. By directing $10 million through USAID, the U.S. can lead the effort to transform health systems in low- and middle-income countries (LMICs), which has the potential to save seventeen million lives per year and avert $12.3 trillion in lost gross domestic product in LMICs over the next 15 years. The investment in surgical systems also supports pandemic preparedness plans as the increased capacity can be repurposed for treatment capacity during pandemics.

The World Bank identified essential surgical care as one of the most cost-effective health interventions available and a health priority that is within reach for countries around the world. Additionally, World Health Assembly adopted a resolution in 2015, co-sponsored by the U.S., which acknowledged surgery and anesthesia as key components to strengthening health systems. As a result, all sixteen member countries of the Southern African Development Community and all twenty-six countries of the Pacific Community are moving ahead to strengthen surgical systems and are developing national strategic plans. In 2020, all thirty-seven countries of the World Health Organization Western Pacific Region unanimously adopted a framework for action for safe and affordable surgery in the region. These LMICs are determined to fill the currently unmet surgical gap of 143 million additional operations by the end of the decade, and the U.S. has an opportunity to lead this global surgery movement.

Congressional Action

Language recognizing the importance of strengthening capacity to address neglected surgical conditions was included in the FY 2021 and FY 2022 State, Foreign Operations, and Related Programs (SFOPS) Reports. Including the proposed language in the FY 2025 SFOPS Report would signify a strong commitment and investment in global surgical care.

CONGRESSIONAL ASK

Senate and House: Include the following language in the final FY 2025 SFOPS Report:

> ***Neglected Surgical Conditions*** *– The agreement includes* ***$10,000,000*** *to strengthen surgical health capacity to address such health issues as cleft lip and cleft palate, club foot, cataracts, hernias, fistulas, and untreated traumatic injuries in underserved areas in developing countries, including in contexts without water or electricity. Strengthening surgical health systems includes the training of local surgical teams to provide safe, sustainable, and timely surgical care, and assisting ministries of health to develop and implement national surgical, obstetric, trauma, and anesthesia plans.*

Ease the Burden of Prior Authorization

Senate and House: Co-sponsor the *Improving Seniors' Timely Access to Care Act* (S. 4532/H.R. 8702). If already a co-sponsor, please urge committees of jurisdiction to advance the legislation.

Surgical patients are encountering barriers to timely access to care due to onerous and unnecessary prior authorization requests from Medicare Advantage (MA) plans. Utilization review tools such as prior authorization can sometimes play a role in ensuring patients receive clinically appropriate treatment while controlling costs. However, the American College of Surgeons is concerned about the growing administrative burdens and the delays in medically necessary care associated with excessive prior authorization requirements.

Congressional Action

The *Improving Seniors' Timely Access to Care Act* (S. 4532/H.R. 8702), introduced by Senators Roger Marshall, MD (R-KS), Kyrsten Sinema (I-AZ), John Thune (R-SD), and Sherrod Brown (D-OH), and Representatives Mike Kelly (R-PA-16), Suzan DelBene (D-WA-01), Larry Bucshon, MD (R-IN-08) and Ami Bera, MD (D-CA-06), is a critical step in improving transparency and efficiency of the prior authorization process in the MA program.

This widely supported legislation, which passed the House of Representatives unanimously in the 117th Congress, would:

- Establish an electronic prior authorization (e-PA) process for MA plans including a standardization for transactions and clinical attachments.
- Increase transparency around MA prior authorization requirements and its use.
- Clarify the Centers for Medicare and Medicaid Services' authority to establish timeframes for e-PA requests including expedited determinations, real-time decisions for routinely approved items and services, and other prior authorization requests.
- Expand beneficiary protections to improve enrollee experiences and outcomes.
- Require the Department of Health and Human Services and other agencies to report to Congress on program integrity efforts and other ways to further improve the e-PA process.

CONGRESSIONAL ASK

Senate and House: Co-sponsor the *Improving Seniors' Timely Access to Care Act* (S. 4532/H.R. 8702). If already a co-sponsor, please urge committees of jurisdiction to advance the legislation.