April 12, 2024

Senator John Barrasso, MD
307 Dirksen Senate Office Building
Washington, D.C. 20510

Senator Debbie Stabenow
731 Hart Senate Office Building
Washington, DC 20510

Senator Marsha Blackburn
357 Dirksen Senate Office Building
Washington, D.C. 20510

Senator John Thune
511 Dirksen Senate Office Building
Washington, DC 20510

Senator Catherine Cortez Masto
520 Hart Senate Office Building
Washington, D.C. 20510

Senator Mark Warner
703 Hart Senate Office Building
Washington, D.C. 20510

RE: Medicare Physician Reimbursement Reform

Senators Barrasso, Blackburn, Cortez Masto, Stabenow, Thune, and Warner:

Thank you for your interest in Medicare physician reimbursement and your willingness to tackle this complex topic. The Emergency Department Practice Management Association (EDPMA) is the nation's only professional trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes and billing, coding, and other professional support organizations that assist healthcare clinicians in our nation's emergency departments. Together, EDPMA members see or support approximately 60% of all annual emergency department visits in the country. For more info, please visit EDPMA.org.

Re-envisioning a plan for improving the quality of and access to physician services provided to Medicare beneficiaries can only occur after Congress first stabilizes the Medicare Physician Fee Schedule (MPFS) through two policies: (1) the creation of an annual inflationary update and (2) the modernization of budget neutrality requirements. Although there are additional substantive reforms that would benefit the MPFS, indexing the MPFS for inflation and modernizing the budget neutrality requirement are critically important, foundational steps that must be taken first. Each of these critical steps is described in turn below. However, we would first like to emphasize the unique impact that Medicare payment instability has on emergency medicine practices.

EMTALA's Unique Impact on Emergency Physicians

Although Medicare reimbursement issues affect all clinicians in the program, emergency medicine providers are in a unique situation compared to nearly every other medical specialty, due to the longstanding federal law EMTALA (Emergency Medical Treatment and Labor Act). Since 1987, EMTALA has provided a statutory guarantee that every patient who presents to an emergency department must be evaluated and medically stabilized regardless of the patient's insurance status or ability to pay for their care. Essentially, 100% of all emergency patients benefit from EMTALA's protections and 100% of emergency care is provided under EMTALA before the physician knows what payment – if any – will be rendered for clinical care. EMTALA is a critical feature of our nation's safety net and emergency care system. EDPMA members are proud to be a pivotal part of that safety net.

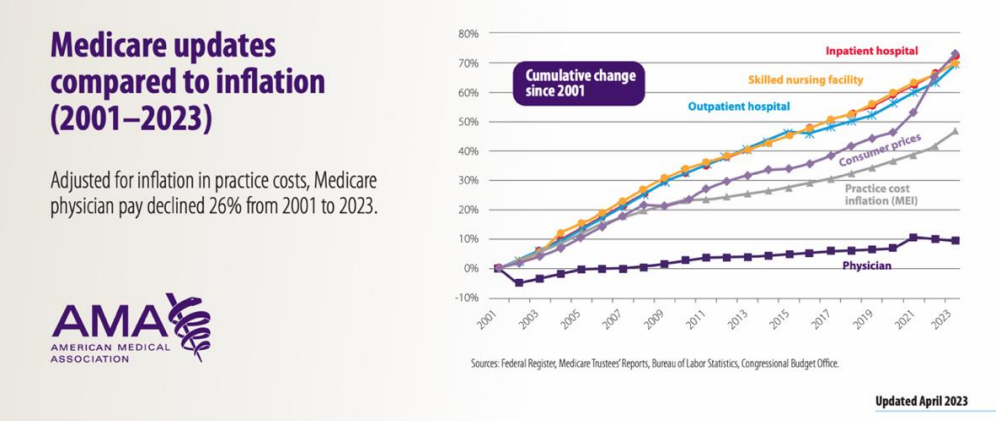
As a direct result of EMTALA, emergency physicians see a broad representation of patients, including uninsured, Medicaid, Medicare, and commercially insured patients (the average proportions are roughly 25% for each payor). It is well established that the ultimate reimbursement for uninsured, Medicaid, and Medicare services is less than the actual cost of providing clinical care to these patients. As a result, on average, EMTALA's requirements create a significant unfunded gap for approximately 75% of the patients seen in our nation's emergency departments. Coupled with significant workforce challenges in recent years, this results in a substantial strain on emergency care practices.

These dynamics also mean that emergency physician practices are highly sensitive to downward movements, fluctuations, and the absence of inflation adjustments for reimbursement rates of all payors, including Medicare. Emergency physician practices cannot adjust to reimbursement decreases in the same way that other specialties can. When reimbursement rates go down or are not adjusted for inflation, other specialties *not* subject to EMTALA have more flexibility to adjust processes for patient financial screening or patient scheduling to ensure the economic stability of their practices. For example, they can first inquire about patients' ability to pay, require insurance information or payments before care is delivered, or refuse to see patients at all in response to reductions or changes in reimbursement. Emergency physician practices have the unique opportunity, but also the affirmative challenge of providing clinical care *first*, and only afterwards collecting appropriate reimbursement to attempt to sustain patient access to care. **This makes emergency care uniquely vulnerable to the downward trend in Medicare reimbursements. To avoid stretching the safety net beyond its breaking point, the emergency medicine community needs the MPFS to be on stable ground before enactment of additional substantive reforms.**

Inflationary Update: Medicare Economic Index

Unlike Medicare's other major payment systems, the MPFS lacks a mechanism to reflect annual inflation, leaving physicians to absorb annual increases in the cost of practice on top of any additional reimbursement reductions. Not surprisingly, this has resulted in physician reimbursement falling significantly behind inflation metrics, behind the reimbursement of all other providers, and well

behind the reimbursement of other sectors of health care, as this graph by the American Medical Association illustrates:



It is imperative that Congress provide a mechanism for physician reimbursement to keep pace with the rising costs of providing medical care. The Medicare Economic Index (MEI) is specifically designed to measure annual increases in the cost of practice. It provides the most relevant inflation metric for the MPFS. For 2024, the MEI is +4.6%. Failure to do so will inevitably result in serious beneficiary access challenges, as noted in the Medicare Trustees' 2023 Report to Congress, which warned that access to Medicare physicians would become "a significant issue in the long term," absent a change in the delivery system or in the level of update. ***The bipartisan Strengthening Medicare for Patients and Providers Act (H.R.2474) would provide an annual inflationary update to the MPFS based on the MEI. This is a basic, foundational policy that will provide stability to the Medicare program. We urge the Congress to enact this legislation.***

Budget Neutrality Threshold

The MPFS is subject to a budget neutrality requirement, by which payment changes over a certain threshold must be offset by reductions in spending that same year. Over the years, certain policy decisions by the Centers for Medicare and Medicaid Services (CMS) have added to reimbursement instability by triggering the statutory requirement for budget neutrality. Most recently, CMS' creation and implementation of a new add-on code (G2211) highlighted the "winners versus losers" dynamic created by this policy: by triggering a Fee Schedule-wide budget neutrality adjustment, implementation of this code alone was responsible for a -2% reduction in Medicare payments for most physicians in 2024 relative to 2023.

Although repeal of budget neutrality in its entirety may not be feasible due to budgetary and scoring implications, Congress must update the threshold at which budget neutrality is triggered. That threshold is set in statute at $20 million, a number that has never been updated since its enactment in the early 1990s. Unless this threshold is updated and then indexed from the updated level, budget neutrality will be triggered more and more frequently as time goes by. That not only creates instability for Medicare clinicians, but it will also make it more difficult for CMS to implement policies to keep

pace with innovation, as even minor policy changes will begin to trigger the need for budget neutrality reductions. To avoid across-the-board reductions in the future, we urge Congress to modernize the threshold at which budget neutrality is triggered. ***Updating the threshold to $53 million would reflect the three decades of inflation since the threshold was first created. Additionally, indexing the new level on a regular basis is a crucial long-term reform that will avoid recreation of the same problem in the future. To accomplish both of these goals, we urge Congress to enact section 5 of the bipartisan Physician Fee Schedule Update and Improvements Act (H.R.6545).***

In closing, we thank you again for your willingness to tackle this complex topic. We hope this feedback is helpful as you consider next steps for Medicare physician reimbursement. For more information, please contact Cathey Wise, EDPMA's Executive Director, at cathey.wise@edpma.org.