



June 14, 2024

Dear Chairman Wyden and Ranking Member Crapo:

The [American Society of Breast Surgeons](#) (ASBrS) is the primary leadership organization for surgeons who treat patients with breast cancer and benign breast diseases. ASBrS is committed to continually improving the practice of breast surgery by serving as an advocate for those who seek excellence in the care of breast patients. Founded in 1995, the Society now has more than 3,100 members throughout the United States and in 35 countries around the world. Active membership is open to surgeons with a special interest in breast disease.

Thank you for your interest in improving chronic care delivery through Medicare Part B physician payment reforms. We were encouraged to see that the bipartisan white paper released on May 17th echoed several of the physician community's concerns related to the structural issues with the Medicare Physician Fee Schedule, as well as the Medicare Trustees' concern about future access challenges, as expressed in their two most recent reports to the Congress.¹

We will focus this submission on what we consider to be the two most pressing structural issues: (1) the lack of an inflationary update and (2) an outdated budget neutrality "trigger." Addressing these two issues in a targeted fashion first will help mitigate the annually recurring cuts experienced by the Fee Schedule every year. In turn, that stability will create the "breathing room" needed to discuss additional reforms, such as improving and accelerating the move to value-based care in Medicare. Additional detail on each of these critical stabilizations is below.

Inflationary Update

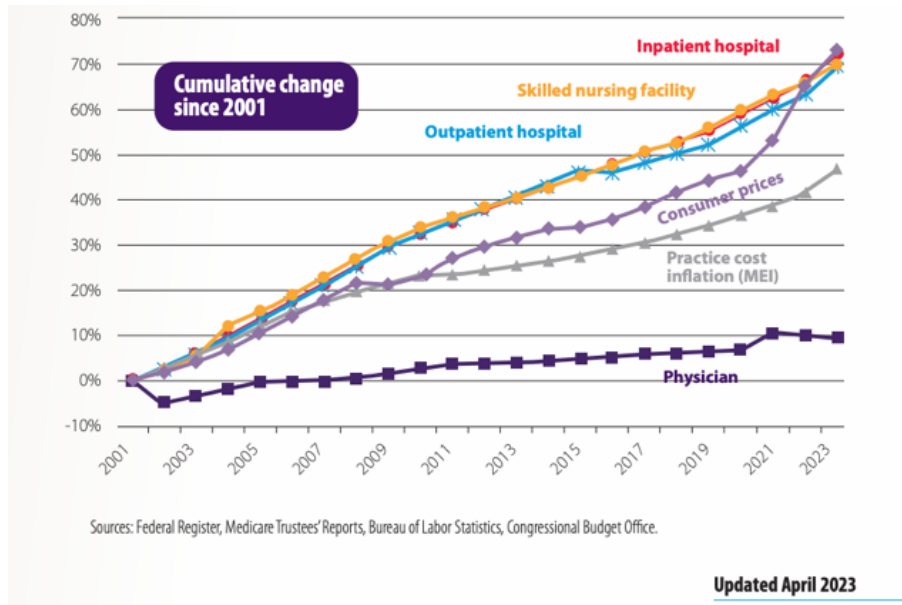
Unlike all other major Medicare payment systems, the statutory provisions governing the Fee Schedule lack a mechanism to incorporate inflation-associated cost increases into the annual rate-setting methodology. As the white paper noted, according to the American Medical Association, adjusted for inflation in practice costs, Medicare payment to physicians declined by a shocking 26% from 2001 to 2023.² By contrast, other providers have been able to keep pace

¹ See, e.g., Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 208 (March 31, 2023). Available: <https://www.cms.gov/oact/tr/2023>.

² See: <https://www.ama-assn.org/system/files/medicare-updates-inflation-chart-cumulative.pdf>.

with inflationary increases, since these are incorporated into the applicable Medicare payment systems:

Medicare Updates Compared to Inflation (Medicare Economic Index) and Other Providers



Source: [American Medical Association](#).

As the graph illustrates, Medicare physicians have acutely felt the impact of the lack of inflationary increases during the recent years of high inflation, but the compounded effects of decades without an inflationary increase against decades of cost increases has created an ever-widening gap between the cost of care delivery to Medicare beneficiaries and the reimbursement for that care. Simply put: each year, it becomes more challenging for Medicare physicians to maintain their practices and deliver more expensive care at reduced reimbursement levels.

Over the years, Congress has intervened to mitigate the Fee Schedule's annually proposed reductions, but these "overrides" have still resulted in cuts to physician payments for the last four years, do not address the underlying issue, and fail to provide certainty to a practice's operations. For private practice physicians, the ability to retain and recruit staff is severely undermined as these practices are competing for the same staff as hospital and other facilities that do receive pay increases to account for inflation. Additionally, the congressional fixes often fall short of making Medicare physicians whole. For example, most recently in March, Congress offset only about half of the 3.4% reduction that had been in effect since January first. While that is better than allowing the full reduction to continue, it still left physicians treating Medicare patients with a payment cut to absorb.



As a final note, the Medicare Economic Index (MEI) – which measures medical practice cost inflation – will be +4.6% in 2024. In other words, if the Fee Schedule could account for MEI in its annual updates, the sting would have been removed from the -3.4% reduction. As it is, without any mechanism to account for inflation, Medicare physicians absorbed a functional -8% cut, on top of the preexisting 2% Medicare sequestration. Although an inflation update is critical in its own right, it becomes a lifeline in the face of seemingly never-ending reductions in reimbursement.

The bipartisan *Strengthening Medicare for Patients and Providers Act* ([H.R.2474](#)) would create an annual inflationary update to the Fee Schedule based on MEI. We urge the Committee to include similar language in any physician payment reform legislative package.

Budget Neutrality

The Fee Schedule is subject to a statutory requirement to offset increases in spending over a certain threshold by commensurate reductions in spending that same year.³ The threshold was set in statute at \$20 million in 1992 and has never been updated since that time. As a result, unless Congress updates the threshold, budget neutrality adjustments will be triggered more frequently with each passing year. Already in the last several years, different policy proposals by the Centers for Medicare and Medicaid Services (CMS) have resulted in across-the-board reductions to the Fee Schedule conversion factor due to the budget neutrality requirement. This requirement has the effect of turning the Fee Schedule into a zero-sum game and puts CMS in the position of having to pick its favorite children. Although elimination of the budget neutrality requirement may not be feasible, at a minimum, the \$20 million threshold must be updated and then regularly adjusted for inflation based on that new updated threshold.

In recent months, the concept of requiring CMS to go through a reconciliation process for its utilization projections has been proposed. Per that proposal, if CMS overestimated utilization as compared to real-world utilization and a budget neutrality cut resulted from that overestimate, the agency would have to “refund” the Fee Schedule. Conversely, if CMS underestimated utilization, it would have to recoup funds from the Fee Schedule that should have been subject to budget neutrality cuts. These recoupments would happen within a capped range, which provides some protection against large fluctuations, but we are concerned about placing liability for erroneous estimates on physicians, who have no input into that process at CMS. Moreover, such a system has the very real potential of creating yet more payment cliffs for Congress to

³ 42 U.S.C. 1395w-4(c)(2)(B)(ii)(II).



address in future years. Even if the potential recoupment cut is capped at -2%, that potential -2% must be considered in the context of the existing -2% Medicare sequestration, the lack of an inflation update, and other potential budget neutrality adjustments for any given year.

There is bipartisan legislation in the House that would modernize the threshold at which budget neutrality is triggered by increasing it from \$20 million to \$53 million, but without creating a recoupment mechanism. The legislation would also require the new threshold to be updated by MEI at five-year intervals. That language is contained in section five of the *Physician Fee Schedule Update and Improvements Act* ([H.R.6545](#)), and we urge the Committee to include that language in any physician payment reform legislation.

In sum, Fee Schedule stabilization is a necessary first step without which other substantive reforms cannot occur. **At a minimum, that stabilization should include the creation of an inflationary update for the Medicare Physician Fee Schedule and the modernization and future indexing of the threshold at which budget neutrality is triggered.**

We hope this initial feedback is helpful as the Committee tackles the complex topic of Medicare physician payment. If we can provide any additional information, please contact Sharon Grutman, Director of Advocacy, Communications, and Quality Initiatives: sgrutman@breastsurgeons.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Judy Boughey', written in a cursive style.

Judy C. Boughey, MD, FACS
President
American Society of Breast Surgeons