



**MEDICAL SOCIETY OF THE STATE OF NEW YORK**  
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September 7, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: File Code CMS-1784-P. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies**

Dear Administrator Brooks-LaSure:

We appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed Medicare Part B payment program for calendar year 2024 (88 Fed. Reg. 52262). As noted below, we echo the concerns with several aspects of this payment rule that have been raised numerous physician advocacy organizations such as the American Medical Association, Physicians Advocacy Institute and numerous state and specialty medical associations.

### **Opposing the Alarming 3.36% Across the Board Cut**

New York's physician community strongly objects to the proposed 3.36% conversion factor reduction in the 2024 Medicare conversion factor (CF), with corresponding reductions in anesthesia CF rates. We are deeply concerned that these proposed cuts will have far-reaching implications for not only physician practices, but more importantly to the patients who rely upon their availability. It is even more offensive that all other health care provider types all receive Medicare payment increases every year, while our physicians on the front lines of patients are being cut.

The proposed payment reductions are attributable to two factors, including a 1.25% reduction stemming from a temporary update and a negative budget neutrality adjustment linked to the introduction of an office visit add-on code. It is evident that these payment cuts are counterproductive to our shared goal of providing high-quality care to Medicare beneficiaries, and simultaneously eroding the financial sustainability of physician practices.

The continued decline in payment rates is unsustainable. From 2001-2023, the cost of operating a medical practice has surged by 47%, while physician payment rates have increased by only nine percent. When adjusted for inflation, Medicare physician payment rates have plummeted by 26%, underscoring the magnitude of the discrepancy between costs and compensation, which is only projected to worsen next year. CMS estimates that the cost to practice medicine as measured by the government's Medicare Economic Index (MEI) is 4.5 percent. This imbalance poses a serious threat to the stability and vitality of medical practices across the nation and contributes to high rates of burnout among physicians.

It also must be understood that New York's physicians already face the highest medical liability insurance premiums in the country and have gone up nearly 10% over the last 2 years. It is because of these, and other exorbitant costs associated with delivering medical care in New York that we are regularly ranked at the bottom of states most favorable for practicing medicine. [2023's Best & Worst States for Doctors \(wallethub.com\)](https://www.wallethub.com/insights/best-worst-states-for-doctors/)

Exacerbating these concerns is the possibility that more physicians and group practices will be hit with a MIPS penalty in 2024 based on the newly released 2022 performance period feedback. These penalties can reduce Medicare payment by as much as 9%. The MIPS program was largely paused during the 2020 and 2021 performance periods due to the COVID-19 public health emergency, and we have serious concerns that it may be unfairly penalizing physician practices—particularly small, independent, and rural practices—due to a lack of awareness of the expiration of the automatic COVID-19 flexibilities. Further, there is growing evidence that this program is unduly burdensome, completely divorced from quality improvement, and exacerbating health inequities. When finalizing its proposals, CMS must consider the totality of the payment reductions facing physicians in 2024.

Moreover, such reductions in physician payment rates will severely hamper access to care for Medicare patients. The Medicare Trustees have explicitly warned that access to Medicare-participating physicians could be seriously compromised in the long term if payment rates fail to adapt. Delays in care, particularly in underserved populations, are associated with worse health outcomes and inequitable health care delivery. It is our shared responsibility to take proactive measures to prevent such outcomes.

While we appreciate that Congress partially mitigated the 4.5% cut to the MFS rates that was supposed to take effect in January 2023 through passage of the Consolidated Appropriations Act (CAA) of 2023, the forthcoming 1.25% reduction in 2024 that was included in the CAA, compounded by a 2% reduction that took effect for 2023, amplifies the financial stress on physician practices. We urge both Congress and CMS to collaborate urgently to address this pressing issue and ensure that physician practices can continue to provide exceptional care without the strain of financial adversity. As a positive step forward, we urge Congress to pass the [Strengthening Medicare for Patients and Providers Act \(HR 2474\)](https://www.congress.gov/bills/117/2474) to help ensure physicians are receiving inflationary updates, just like other Medicare providers

receive. Federal spending must not be balanced on the backs of patients and their physicians.

### **Concern with Utilization Assumptions for E/M Add-On Codes**

CMS has taken a positive step by reducing the utilization assumption for the G2211 E/M add-on code from 90% under the previous administration to 38% in the current proposed rule. However, we share the concerns raised by many other advocacy groups regarding the utilization assumptions for G2211, which are a major driving factor leading the 2024 conversion factor cut proposed by CMS. The lack of clarity surrounding the appropriate circumstances for reporting this code, combined with potential implications for patient cost-sharing, has created significant ambiguity among health care practitioners. We urge CMS to further refine these assumptions to prevent reductions in the Medicare conversion factor that may, in fact, not be warranted by actual usage.

### **Practice Expense Data**

We thank CMS for its decision to delay implementation of the flawed Medicare Economic Index (MEI) cost weights pending more public comment and completion of the AMA's Physician Practice Information Survey (PPIS) that will collect practice expense data directly from physician practices rather than using surrogate data sources. We believe that waiting for more direct physician data in determining the appropriate MEI cost weights and the mechanisms for computing those weights will result in more accurate information on which to base payment. The AMA and Mathematic formally launched the PPI Survey on July 31, 2023. The survey is supported by 173 health care organizations and will provide more than 10,000 physician practices with the opportunity to share their practice cost data and number of direct patient care hours provided by both physicians and other qualified healthcare professionals. The surveys will be in the field through April 2024 and data will be shared with CMS in early 2025 for the 2026 Medicare Physician Payment Rule which also coincides with the 2026 GPCI update.

During 2023, nine of the largest state medical associations led by CMA met with the Centers for Medicare and Medicaid Services (CMS) to discuss the negative impact of the 2024 Medicare Economic Index (MEI) reweighting plan on physicians in our states. The proposal would have rebased and revised the Medicare Economic Index practice expense GPICs. It would have harmed the majority of physician practices in our higher-cost regions and made it more difficult for physicians to operate viable medical practices and maintain patient access to care. The State Impact Chart (developed by the California Medical Association) below shows at least \$230 million in net reduced payments per year to physicians in nine high-cost states as a result of the 2024 MEI changes. Over \$30 million would have been shifted away from New York physicians. These losses will increase significantly in future years as new Medicare Advantage plan county benchmarks become impacted by actual changes in Fee-for-Service per capita expenditures.

	Alt peGPCI Impact Using 2020 RVUs	Est 2024 Impact*
CA	\$ (74,052,602)	\$ (86,631,071)
DC	\$ (18,679,706)	\$ (21,852,613)
FL	\$ (52,366,355)	\$ (61,261,229)
HI	\$ (2,853,347)	\$ (3,338,012)
MD	\$ (6,352,043)	\$ (7,430,991)
MA	\$ (5,236,808)	\$ (6,126,325)
NJ	\$ (10,526,005)	\$ (12,313,937)
NY	\$ (25,759,151)	\$ (30,134,563)
TX	\$ (1,446,917)	\$ (1,692,688)
	*-4% annual increase in RVUs	

The flawed plan inaccurately redistributed physician payments between geographic regions without any scientific basis. CMS did not apply appropriate physician practice data or make appropriate calculations. Unfortunately, the plan resulted in inaccurate payment rates that would reduce access to physicians in high-cost regions of the country, inconsistent with the intent of the Medicare geographic payment law. The substantial geographic redistributions were not based on accurate data. For instance, CMS proposed to reduce the weight of office rent from 10.2% of all physician practice expenses to 5.6% which would lead to substantial reductions in Medicare reimbursement in high-cost urban areas, and particularly to small practices where office rent can comprise 16% of total expenses. Based on our samples of office practices, we believed rent was undervalued and the purchased services category was overvalued in the plan. Moreover, there was a great deal of variation in practice expense weights between geographic regions. As CMS is also aware, nursing, and other staff wages have skyrocketed in urban regions. Overall, the plan could incentivize physicians to provide certain services in more expensive settings which would unnecessarily drive-up costs.

It is also important to note that because of the 1/4 work GPCI adjustment, 3/4 of the work GPCI is not applied to Medicare payments for most physicians in the country and therefore, physician work is already devalued. The CMS plan will exacerbate this discrepancy for physicians in higher-cost regions.

The states listed in the chart above are extremely concerned with the declining trends in patient access to care because of the already low Medicare rates. If Medicare payment rates are reduced even further in our high-cost regions, it will exacerbate our access to care challenges. We believe the reweighting plan will harm small practices, further incentivize the provision of services in more expensive hospital settings, and reduce access to care, particularly for patients with more costly, complex conditions. Under the CMS plan, physicians operating on tight financial margins will be further disincentivized to care for patients with chronic conditions or serve underserved and marginalized communities.

## **Part B Payment Policies for Telehealth**

While CMS has finalized the extension of certain telehealth flexibilities and has made other flexibilities more permanent, there remains a gap in the ability to provide telemedicine services in the home and appropriate reimbursements for these services post-PHE. We urge the following by CMS:

- Continue telehealth flexibilities permanently and reimburse telehealth services at parity with in-person service rates.
- Maintain the flexibility for physicians to render telehealth services from their homes without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.
- Ensure that any future policies looking to expand telehealth coverage in Medicare do not expand the scope of practice of non-physician health care professionals beyond that supported by their licensure, education, and training.

Thank you for your attention to our comments. New York's physicians continue to stand on the front lines of care for patients and continue to be adversely impacted financially by the pandemic. CMS should ensure that all finalized policies account for these challenges as well as the importance of supporting all physicians including small and independent practices. Without the comprehensive supply of community and hospital-based physicians, patients' access to care with suffer.

Sincerely,

A handwritten signature in black ink that reads "Paul A. Pipia, MD". The signature is written in a cursive, flowing style.

**PAUL A. PIPIA, MD**  
**MSSNY President**