

## Stop Cuts to Medicare Physician Payment

**Senate and House:** Stop Medicare physician payment cuts and oppose implementation of the G2211 add-on code.

For more than 20 years, Medicare payments have been under pressure from 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. The Medicare Physician Fee Schedule (PFS) is unique in its lack of a meaningful mechanism to account for inflation and remains constrained by a budget-neutral financing system. 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 2024.

### Congressional Action

Last year, Congress took action to mitigate part of the recent PFS cuts, however, Medicare payment continues to decline year after year. The Calendar Year (CY) 2024 proposed rule includes a nearly 3.5% cut to surgeons, physicians, and other health care professionals and the G2211 add-on code accounts for more than half of this cut. **Congress can stop implementation of G2211 and eliminate a majority of the expected 2024 Medicare physician payment cut at no cost to the federal government.**

In 2020, Congress recognized the problems posed by the G2211 add-on code and delayed its implementation for three years. During that time, CMS did not address the flaws with G2211 and, unfortunately, there has been no congressional action on long-term reforms to fix the broken payment system. Under the coding structure for office visits (evaluation and management (E/M) coding), physicians and qualified health care professionals have the flexibility to bill a higher-level E/M code to account for increased medical decision-making or total time of the encounter. Because G2211 is already duplicative of work already represented by existing codes, there is no longer justification for implementation of the code. This add-on code will result in “double dipping” for those using it while at the same time penalizing all physicians due to a reduction in the Medicare conversion factor caused by budget neutrality requirements under the PFS.

A flawed G2211 on top of a broken Medicare physician payment system would be incredibly harmful to the health care system. In the short-term, Congress should stop implementation of the G2211 add-on code. The ACS remains committed to partnering with Congress to identify policy solutions to ensure long-term stability of the Medicare PFS and advance other necessary reforms.

### CONGRESSIONAL ASK

**Senate and House:** Stop Medicare physician payment cuts and oppose implementation of the G2211 add-on code.

# ADVOCACY AT HOME

## Reauthorize the Pandemic and All Hazards Preparedness Act (PAHPA)

**Senate and House:** Ensure PAHPA reauthorization includes ACS priorities.

PAHPA was enacted to improve the nation's response to public health and medical emergencies and was last authorized in 2019. As part of the process to reauthorize the legislation, both the House Energy and Commerce and Senate Health, Education, Labor and Pensions Committees have released proposed bills that seek to strengthen and improve the programs that directly affect public health preparedness and response. Trauma systems are organized across the country to manage, on a daily basis, acutely injured patients in an efficient, time-sensitive manner and spans the continuum of care from the point of injury through rehabilitation. As a result, these systems are responsible for day-to-day emergency and trauma care, but also scale up for public health emergencies that cause regions to experience a surge in capacity, serving as critical infrastructure for disaster and emergency response.

Without Congressional action, these important programs will expire on September 30, 2023. The ACS urges Congress to reauthorize PAHPA and ensure the following priorities are included in the final package.

- **Language in Sec. 103 of *Pandemic and All-Hazards Preparedness and Response Act (S. 2333)*:** There is broad variability in the quality, continuity, and access to trauma care—which leaves many Americans at risk for injury, death, and disability. A health care system that can oversee and coordinate daily medical needs is key to surging when needed in an emergency scenario. S. 2333 contains language in Section 103 that reauthorizes the Hospital Preparedness Program (HPP), 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.
- **Reauthorize *MISSION ZERO (H.R. 2416)*:** *The MISSION ZERO Act* was enacted in 2019 as part of PAHPA, establishing the Military and Civilian Partnership for the Trauma Readiness Grant program. The grant program is managed through the Administration for Strategic Preparedness and Response (ASPR) and covers the civilian administrative costs of embedding military trauma professionals in civilian trauma centers. These military-civilian trauma care partnerships allow military trauma care teams and providers 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 ACS urges reauthorization of this important program at the same level of \$11.5 million.

# ADVOCACY AT HOME

- **Include language from the *Good Samaritan Health Professionals Act* (H.R. 2819):** Rapid medical response in a disaster can greatly decrease loss of life and improve outcomes for patients who desperately need assistance. Due to inconsistent state laws and lack of federal policy, it is often unclear whether protections against unnecessary lawsuits exist for medical volunteers who cross state lines. Therefore, the ACS urges Congress to include the *Good Samaritan Health Professionals Act*, which provides volunteer health professionals with the same level of civil immunity they receive in their home state when providing care in a federally declared emergency. Removing barriers that prohibit licensed surgeons and other qualified physicians from voluntarily administering medically necessary care during disasters will ensure access to high-quality surgical services in the event of a crisis.

## CONGRESSIONAL ASK

**Senate and House:** The final PAHPA Reauthorization bill should include the following ACS priorities:

- Maintain language contained in Sec. 103 of S. 2333 in the final PAHPA legislative package;
- Reauthorize the *MISSION ZERO Act* (H.R. 2416);
- Include language from the *Good Samaritan Health Professionals Act* (H.R. 2819).

## Ensure Access to General Surgery

**Senate and House:** Co-sponsor the *Ensuring Access to General Surgery Act* (S. 1140/H.R. 1781).

General surgery is an essential element of a community-based health system. A shortage of general surgeons is a critical component of the ongoing crisis in the health care workforce because surgeons are the only physicians uniquely trained and qualified to provide certain necessary, lifesaving procedures. In areas without general surgeons or 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 U.S., with supply only able to meet approximately 69% of demand in rural areas and 75% of demand in suburban areas. Likewise, a 2021 report from the WWAMI Rural Health Research Center found that between 2001 and 2019, rural areas experienced a 29.1% decrease in the supply of general surgeons, and in 2019, 60.1% of non-metropolitan counties had no active general surgeon at all. While this is useful information, current available data are not able to indicate if the supply of general surgeons in a given geographic area is adequate to provide access to the services demanded by the population, largely because there is no agreed-upon definition of what constitutes a surgical shortage.

Optimal quality, the centerpiece of ACS' mission, is not achievable without optimal access. ACS believes that current data highlight the urgent need to establish a surgical shortage designation.

### Congressional Action

ACS strongly supports 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-07), John Joyce, MD (R-PA-13), and Scott Peters (D-CA-50). This important legislation 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 access to the full spectrum of high-quality health care services.

### CONGRESSIONAL ASK

**Senate and House:** Co-sponsor the *Ensuring Access to General Surgery Act* (S. 1140/H.R. 1781).

## Support Legislation Banning Non-Compete Agreements

**Senate and House:** Co-sponsor the *Workforce Mobility Act* (S. 220/H.R. 731)

Non-compete agreements, also known as restrictive covenants, are provisions in employment contracts that can prohibit individuals from joining a competing firm or starting a new venture in the same field after leaving their employer. Non-competes are common in employment contracts, including those in the health care sector. Unfortunately, many employed surgeons are subject to contractual terms which include a restrictive covenant 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 the current employer.

### Congressional Action

The *Workforce Mobility Act* (S. 220/ H.R. 731) was introduced by Senators Chris Murphy (D-CT), Todd Young (R-IN), Tim Kaine (D-VA), and Kevin Cramer (R-ND) in the Senate and Representatives Scott Peters (D-CA-50) and Mike Gallagher (R-WI-08) in the House. It would prohibit employer non-compete agreements under federal law, with limited exceptions. Specifically, the legislation would:

- Allow non-compete agreements only in necessary instances such as the dissolution of a partnership or the sale of a business;
- Require employers to inform employees about the limitation on non-competes;
- Grant the Department of Labor authority to carry out public awareness efforts of the new limitations;
- Charge the Federal Trade Commission and the Department of Labor with enforcement, as well as make explicit a private right of action in federal court;
- Require the Federal Trade Commission and the Department of Labor to submit a report to Congress on any enforcement actions taken.

The *Workforce Mobility Act* 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 *Workforce Mobility Act* (S. 220/H.R. 731) to help ensure surgeons are free to practice where they choose.

## Support the Physician Workforce by Addressing Student Loan Debt

**Senate and House:** Co-sponsor the *Resident Education Deferred Interest (REDI) Act* (S. 704/ H.R. 1202) and the *Specialty Physicians Advancing Rural Care (SPARC) Act* (S. 705/H.R. 2761).

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. A 2021 report released by the American Association of Medical Colleges projects shortages of 15,800-30,200 in all surgical specialties by 2034. A shortage of surgeons is a key component of the crisis in the health care workforce and patient access to health care services because surgeons are the only physicians who are uniquely trained and qualified to provide certain necessary, lifesaving procedures.

The high cost of medical education contributes to the ongoing physician shortage. 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.

### Congressional Action

Lawmakers have introduced two bills aimed at supporting the physician workforce by addressing student debt associated with medical education. 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 John Joyce, MD (R-PA-13) 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.

### CONGRESSIONAL ASK

**Senate and House:** Co-sponsor the *REDI Act* (S. 704/H.R. 1202) and the *SPARC Act* (S. 705/H.R. 2761).