

**BOLSTERING CHRONIC CARE THROUGH
MEDICARE PHYSICIAN PAYMENT**

HEARING

BEFORE THE

**COMMITTEE ON FINANCE
UNITED STATES SENATE**

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BOLSTERING CHRONIC CARE THROUGH MEDICARE PHYSICIAN PAYMENT

THURSDAY, APRIL 11, 2024

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:04 a.m., in Room SD-215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Warner, Whitehouse, Hassan, Warren, Crapo, Grassley, Lankford, Johnson, Tillis, and Blackburn.

Also present: Democratic staff: Shawn Bishop, Chief Health Advisor; Eva DuGoff, Senior Health Advisor; Marisa Salemm, Senior Health Advisor; Joshua Sheinkman, Staff Director; and Tiffany Smith, Deputy Staff Director and Chief Counsel. Republican staff: Kellie McConnell, Health Policy Director; Gregg Richard, Staff Director; and Conor Sheehey, Senior Health Policy Advisor.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order, and today we are going to discuss how to update and strengthen Medicare's guarantee of high-quality health benefits for the next generation of America's seniors. To be clear from the outset, traditional Medicare, now used by millions of older people to secure the vital services of Medicare, is falling behind when it comes to helping seniors manage their health when they are living with multiple chronic conditions.

I know members of the committee are interested in reforms to the way physicians and nonphysician practitioners are paid. In my view, any update to the way physicians are paid by traditional Medicare has to provide a lifeline to those older folks that I was talking about: the millions of seniors who live with chronic conditions and who are struggling to coordinate their health care in a fragmented system, in a peculiar, crazy quilt of services that just does not put seniors' health first. This hearing is going to jumpstart that debate.

The Finance Committee has had a special interest in this. I believe this was before our colleague from New Hampshire joined us, but we delivered a wake-up call to the country when we passed our first round of reforms to care for chronic conditions in Medicare. I remember those days like it was yesterday, because the late Orrin Hatch, the chairman of our committee, had some concerns about the original idea, and Johnny Isakson of Georgia and Senator War-

ner and I and others were kind of the agitators, and the chairman agreed to work closely with us. And we made the point that—and it's critical today—Medicare is no longer just an acute care program.

Back in the days when I was director of the Gray Panthers and I had a full head of hair and rugged good looks, that was Medicare. You know, you broke your ankle, and that was Part A of Medicare. You went to the hospital. If you had a really horrendous case of the flu, that was Part B of Medicare. That was the ballgame. In our gerontology classes, we taught that: Part A, Part B, the end.

That is no longer Medicare. Today, Medicare is overwhelmingly about chronic conditions: cancer, diabetes, heart disease, strokes, COPD—you all know the list. And what we know is that if you do not figure out ways to pull these services together, as I mentioned, you have this crazy quilt of appointments and prescriptions and care plans that lead to confusion and, particularly, worse health care.

When a senior's health gets this complicated, care coordination is not an option. Recent events have underlined the growing cost of chronic disease in America. Even before the COVID-19 pandemic, life expectancy began to dip in the United States from a 2014 peak of 79 years old. The pandemic led to a backlog of preventive care that may only accelerate chronic illness in our country.

The way traditional Medicare pays physicians to manage and treat these conditions has not kept up with the times. Democrats and Republicans were right to tackle the problem earlier. It is now time to act once more. In contrast to traditional Medicare in the past decade, Medicare Advantage plans have been given a host of tools to incorporate chronic disease management into their plan choices.

We talked about it, and it is all about giving flexibility to plans. And the irony of course is, a lot of these additions were really quite expensive in terms of their cost, but they could make a difference for seniors—even grab bars in showers.

Now, I have people who run ambulance systems who say “thank goodness for those grab bars,” because we do not see as many older people who have hips that are shattered getting out of bathtubs. So, these are important kinds of health-care issues, and ones that can be addressed with services that are not particularly expensive.

So, MA was built from the ground up to offer more flexible benefits, to give seniors the option to choose a Medicare plan that was tailored to their needs. Plans are able to use rebates, growing from \$12 billion in 2014 to \$67 billion in 2024, to support this idea of the flexibilities and the added benefits. Unfortunately, it is increasingly clear that too many insurance companies are playing too many games with these rules, particularly in terms of coding games with Medicare's payment rules to maximize their bottom line but do little or nothing for seniors. MA plans seem, in too many instances, to be using more of these extra dollars to juice marketing and enrollment.

We have been told by experts that MA plans are now spending \$6 billion per year on marketing middlemen. Get that number, colleagues: \$6 billion on marketing middlemen who sell their plans to seniors. Just last week at our request, the Centers for Medicare

and Medicaid Services announced they are cracking down on these insurance middlemen selling seniors' personal information over and over again. So what this means, colleagues, is an insurance plan gets some personal data from somebody and then, after they get their data from the consumer, they just sell it over and over again. We pushed to get that outlawed, and that is in fact going to be done.

Now, there is plenty more that we need to do in terms of getting traditional Medicare to keep up with the needs of seniors when it comes to care coordination, nonmedical determinations of health, and the like. This could include steps such as reducing or eliminating cost sharing for care coordination services. Seniors should not have to pick up the tab when their primary care doctor works with their cardiologist or physical therapist to coordinate a care plan for high blood pressure. It also has to include empowering primary care. The physicians and the providers who do that play a critical role in managing chronic illness.

We also have a persistent shortage of primary care providers in many parts of the country. That is because there are out-of-whack payment rules that make primary care a less appealing specialty than other fields. Primary care providers need to be valued and compensated more fully by Medicare.

Finally, the challenge before the Finance Committee is to improve the way Medicare pays for services delivered in the doctor's office or at home, so there is a real focus on managing those chronic conditions that dominate the health of seniors.

Last point I want to make, colleagues, is when we got the original bill passed—and it shows what we can do here in this committee working in a bipartisan way, with a bit of imagination—a major section of our chronic care bill was devoted to telehealth services. They were big, and they just sat there plopped right in the center of the bill, and for a year or two nobody paid a lot of attention. One day I was sitting in my office, and President Trump's director of CMS called me up and said, "How would you feel if we were to use your telemedicine provisions as the basis for dealing with COVID?" I said, "Are you kidding me? How would I feel? I am going to go and have two hot fudge sundaes. This is wonderful." This is an indication that the Finance Committee, on a bipartisan basis, can make a difference.

We are still building on that model. So I am going to turn this over to Senator Crapo, but I just bring this up by way of saying that this committee, working in a bipartisan way, did something historic with this change to make Medicare focus as much on chronic care as it does on acute care. We have to keep building on it, and it really speaks to what these four witnesses are going to be talking about today, so we thank you.

Senator Crapo?

[The prepared statement of Chairman Wyden appears in the appendix.]

**OPENING STATEMENT OF HON. MIKE CRAPO,
A U.S. SENATOR FROM IDAHO**

Senator CRAPO. Thank you, Mr. Chairman, and thank you for holding this important hearing. We can build strong bipartisanship and have done so in this area many, many times.

Across the country, more than 60 million Americans rely on Medicare to meet their health-care needs. Over the next decade, this population will grow by more than 20 percent. Medicare's coverage and payment policies play a dominant role in setting benchmarks and baseline rules of the road, not just for the program itself, but also for countless other payers, affecting hundreds of millions of working families.

In short, ensuring a resilient and robust Medicare program has become more vital than ever. Unfortunately, our current policies seem poised to fall short of that goal. Today's hearing highlights the urgency of advancing durable clinician payment reforms, both for front-line medical providers and, more importantly, for patients.

In the absence of proactive policy changes, tens of millions of seniors will suffer the consequences. The risks of inaction range from surges in wait times and delays including for critical care, to clinician office closures and cutbacks in provider participation.

Our committee has an obligation to strengthen the Medicare program and avert these unacceptable outcomes. A successful legislative initiative must reckon with the range of challenges under the current paradigm, which has served to devalue and distort payments for vital services, as well as to exacerbate administrative burdens.

In inflation-adjusted terms, Medicare Physician Fee Schedule payments have declined by more than 25 percent over the past 2 decades, even as clinicians continue to face skyrocketing costs for overhead, equipment, supplies, and staffing needs. As the Medicare trustees cautioned last year, the colossal gap between stagnant fees and steep inflation poses a dire threat to long-term patient access. The current conversion factor update schedule cannot sustain an effective or even adequate clinical workforce moving forward.

For many specialists, recent regulatory changes have further intensified these issues, as new billing codes and valuation shifts have triggered drastic cuts under the program's budget-neutrality rules. Based on inflexible cost-containment measures, a payment bump for primary care prompts payment reductions for entirely unrelated procedures and services, from brain surgery to advanced cancer care.

From 2014 to 2023, for instance, even before adjusting for inflation, the fees for chemotherapy administration and IV infusions declined. Under these conditions, it should come as no surprise that many physicians have opted to sell their practices, join health systems, or limit new Medicare patients.

Structural fee schedule reforms should shift away from the status quo—which forces clinicians to vie for ever-dwindling resources—and move forward to models that promote and reward team-based, patient-centered approaches. Nine years ago, Congress took concerted action to repeal the draconian Sustainable Growth Rate system, which had threatened cascades of dramatic cuts. In enacting the Medicare Access and CHIP Reauthorization Act, pol-

icymakers sought to stabilize the fee schedule and incentivize value-based care. In practice, these reforms have largely failed. The Merit-based Incentive Payment System aimed to establish an accessible on-ramp to participation in quality-driven alternative payment models, or APMs.

Instead, this system has buried clinicians in dozens of hours of paperwork each year, all in exchange for potential marginal payment bumps based on ambiguous metrics that lack meaningful value for patients. A number of primary-care-focused APMs have shown promise, but countless specialties lack access to any clinically relevant models at all.

While the MACRA-established committee to translate clinician-developed APM concepts into concrete policy options has worked through dozens of viable proposals, the Centers for Medicare and Medicaid Services have largely rejected these opportunities. Reforms to advance value-based care thus demand a focus not just on financial incentives, but also on structural improvements that ensure meaningful options informed by clinical experience and aligned with patient needs.

I look forward to building on this committee's bipartisan work to bolster and modernize our clinician payment systems. The program's current and future enrollees depend on it.

Thank you to our witnesses for being here today, and thank you, Mr. Chairman.

[The prepared statement of Senator Crapo appears in the appendix.]

THE CHAIRMAN. Thank you, and we have four individuals who, by any objective assessment, are real experts in chronic care. So we thank you, and we have some brief introductions. We will go right to your testimony.

Dr. Amol Navathe is a practicing primary care physician, and an associate professor of health policy and medicine at the University of Pennsylvania. He is also vice chairman of MedPAC, the Medicare Payment Advisory Commission.

Dr. Steve Furr is here. He is a family physician and president of the American Academy of Family Physicians. He also cofounded a clinic as well in Jackson, AL to serve folks there.

Dr. Patricia Turner is a general surgeon and chief executive officer of the American College of Surgeons, and she is also a professor at the University of Chicago. We welcome you.

And then, Melanie Matthews is chief executive officer of Physicians of Southwest Washington and president of MultiCare Connected Care.

To all of our witnesses, we thank you for speaking with the Finance Committee about these extraordinarily important issues—chronic care and particularly the Medicare physician payment system. Please go ahead with your remarks. As you know, we are trying to keep everybody at 5 minutes, because we think members—it is going to be a hectic morning here in the Senate—are very interested in these issues.

Dr. Navathe, please start.

STATEMENT OF AMOL S. NAVATHE, M.D., Ph.D., PROFESSOR OF HEALTH POLICY, MEDICINE, AND HEALTHCARE MANAGEMENT, PERELMAN SCHOOL OF MEDICINE AND THE WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA

Dr. NAVATHE. Chairman Wyden, Ranking Member Crapo, and distinguished members of the committee, thank you for the opportunity to testify. My name is Amol Navathe. I am a general internist, physician, and health economist.

Before I begin my remarks, I would like to emphasize that my comments reflect solely my beliefs, and not the opinions of any organization I am affiliated with, including MedPAC, the University of Pennsylvania Health System, or Perelman School of Medicine.

Today, I would like to highlight why the Medicare program needs to better address chronic disease care, and why this cannot happen without changes to physician payment. As a practicing physician, I have witnessed firsthand the challenges that Medicare beneficiaries face in getting optimal care for chronic conditions.

Take for example my patient Mr. L, a wonderful gentleman suffering from diabetes, heart failure, and kidney disease. Mr. L has to manage his chronic conditions on his own, spending an average of 2 hours a day coordinating his medications, traveling to clinics, and attending appointments. He is one of so many patients who would benefit from a more proactive patient-centered model of care, a model that could have prevented his recent hospitalization for kidney failure. In reflecting upon Mr. L's situation, I would like to share three key points.

First, chronic disease may be the single most important challenge affecting the Medicare program. More than two-thirds of the Medicare population has two or more chronic conditions. The 15 percent of beneficiaries with six or more chronic conditions cost Medicare more than three times the average.

Second, dramatic fragmentation plagues chronic disease care. Medicare beneficiaries with chronic conditions see more than five physicians concurrently. My colleague Matt Press found that over just 3 months, it takes a PCP over 50 interactions—let me say that again—50 interactions with other clinicians and the patient, to actively coordinate care for just one important clinical condition. It is pretty astounding how much time and effort this takes.

What does this have to do with physician payment? That leads me to my third point. Unfortunately, the status quo fee-for-service system is a key factor in producing fragmentation. The focus is not on producing more health, just on producing more health care. Each clinician has their head down, focused on doing more visits and procedures, while the critical task of coordinating care often gets overlooked.

With good intentions, CMS has attempted to fill this gap by adding more billing codes. But reducing the important work of clinicians to a list of codes is a fraught task. The result is an administratively complex system of ticky-tack codes that are underused because the cost of billing them is itself unprofitable. For example, the administrative cost to bill for a visit is about \$20. That is more than the \$15 physicians get paid for a virtual check-in visit. I sometimes call this death from a thousand codes.

So what is the path forward? Addressing fragmentation will require a new way of delivering chronic disease care, which in turn will require substantial changes to physician payment. Simply adding more dollars to the current system will not be enough. Physician groups need to be able to invest in new capabilities; use technologies like telehealth when safe, efficient, and effective; and staff practices differently.

A natural place to start is investing in primary care. One promising path is to provide PCPs with steady monthly payments per beneficiary, in addition to certain fee-for-service payments. This would balance the roles of preserving access, while enabling PCPs to practice more patient-centered care. An additional benefit would be unshackling PCPs from a system that requires billing for each and every task.

Another promising approach is to continue expansion of alternative payment models, which place accountability for cost and quality outcomes onto providers. This will require continued support from the CMS Innovation Center. Alternative payment models can improve care for patients with both high and low burdens of chronic disease. A great example has been the Accountable Care Organization model. However, alternative payment models still rely on the Physician Fee Schedule, creating conflicting incentives for some physicians. This leads me to point out that CMS needs more tools to manage the fee-for-service program effectively.

There are many factors to consider in improving physician payment, and no single entity has all the required expertise. This effort will benefit from the input of multidisciplinary experts, who could be convened as an advisory panel to CMS. Ultimately, CMS needs the ability to catalyze a new care model, and that will require adapting the fee schedule to accommodate new approaches, such as for primary care. This will require action. Unlike in Medicare Advantage, where we have seen substantial innovation to meet beneficiary needs on a near real-time basis, traditional Medicare requires congressional action to stay up to date. Hence, CMS needs more tools and authorities to better address chronic disease among Medicare beneficiaries.

Thank you.

[The prepared statement of Dr. Navathe appears in the appendix.]

The CHAIRMAN. Dr. Navathe, we have had some jaw-dropping testimony around here over the years, but to hear that one patient had 50 interventions—was that your word, or interactions?

Dr. NAVATHE. Interactions.

The CHAIRMAN. Yes. Fifty interactions over a 3-month period. I am going to be replacing my jaw or something. That was really extraordinary, and I think that also gives us a wake-up call like we had years earlier when we started down this path. And I thank you.

Dr. Furr?

**STATEMENT OF STEVEN P. FURR, M.D., FAAFP, PRESIDENT,
AMERICAN ACADEMY OF FAMILY PHYSICIANS, JACKSON, AL**

Dr. FURR. Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee; I am Steve Furr. I am a

practicing family physician from Jackson, AL, population slightly less than 5,000. I am the president of the American Academy of Family Physicians. I am honored to be with you here today, representing our 130,000 members, physicians, and medical students who faithfully serve their patients and your constituents.

I have delivered primary care in a rural community for more than 35 years. In my time, I have seen firsthand how my patients are getting sicker and more complex. Meeting the current and future needs of our patients with chronic conditions requires our Nation to better leverage primary care.

On March the 21st, Carolyn, my long-term patient, came to my office complaining that she had a blister on her right great toe. Carolyn and I were born in the very same year, but our life paths are very different. But we have walked them together as physician and patient. She is a diabetic on short- and long-acting insulin, and between her diabetes and her hypertension, her kidneys failed. She was on dialysis and then was fortunate enough to get a kidney transplant. Now she is on chronic immunosuppressive therapy. She comes to my office and as I examine her, I can smell the putrid odor from her toe, and I know that she has a necrotic foot.

I clean and debride the wound, get the x-ray confirming infection has not moved into the bone. The vascular studies showed what we suspected. She has no blood flow from the knee down to the rest of her foot. She saw the vascular surgeon on Tuesday this week, and will hopefully get a revascularization procedure that will save that leg. If she is not treated in time, she would get a very different procedure, a left above-the-knee amputation, leaving more morbidity and mortality. One of the most impactful aspects of primary care is the trusting relationship we develop with our patients.

Evidence suggests that the longitudinal relationships that I and other primary care physicians foster with our patients lead to better control of chronic conditions, fewer emergency department visits and hospital stays, and improved patient outcomes. But traditional Medicare underinvests in primary care and these relationships. Lower primary care payment rates and a system that rewards volume over value means physicians are pressured to see as many patients as possible.

Meanwhile, overwhelming administrative burden takes significant time away from our patient care. This is leading current primary care physicians to leave the field, and discouraging medical students from pursuing primary care specialties. This in turn is having severe impacts on patient access. Among peer nations, the patients in our country are the least likely to have a longstanding relationship with a primary care physician. Our health-care system has steered people away from high-value, low-cost services like preventive screenings and primary care office visits.

By not investing more up-front dollars in primary care, we are paying an even higher price, and we are not prioritizing what really matters: patient outcomes and experience. One of the major factors contributing to our national underinvestment in primary care is a relative undervaluation of primary care in fee-for-service payment. In general, Medicare values procedural services higher than it does office visits and other cognitive services most often delivered by primary care physicians. This devaluation is not limited to

Medicare. As mentioned earlier, most payers tie their payment rates to Medicare or use Medicare-relative values.

Fee-for-service does not just underinvest in primary care; it also makes it hard to get paid. We must submit multiple unique codes for each service we provide, documenting both what we did and why we did it. That does not fit with the continuous, comprehensive nature of the primary care that we provide.

That is why we must accelerate the transition to value-based payment for primary care, using alternative payment models, or APMs, that provide prospective population-based payments. However, it is important to realize APMs are often designed based on fee-for-service payment rates. Therefore, improving fee-for-service payment for primary care is one essential strategy to support the transition into value-based care.

I am encouraged by the recent policy changes to better value primary care Medicare. Unfortunately, Medicare's budget-neutrality requirements for physician payment are severely undermining these investments. CMS is forced to offset increases anywhere in the fee schedule with across-the-board cuts to all services, including primary care. This means Medicare cannot appropriately pay for all the services a patient might need.

So, as a first step forward, I would ask that Congress revise current budget-neutrality requirements. Additionally, Congress should waive patient cost-sharing requirements for chronic care management and other primary care services. In closing, I urge Congress to prioritize policies that would better support patients with chronic conditions and the family physicians who care for them. We all have the same goal: to improve the lives of the people we serve.

Thank you for the opportunity to provide this testimony. I look forward to trying to answer your questions.

[The prepared statement of Dr. Furr appears in the appendix.]

The CHAIRMAN. Doctor, thank you, and good for you for taking the principles that you have advocated and putting them into action there at home. Nice to have you.

Dr. Turner?

STATEMENT OF PATRICIA L. TURNER, M.D., MBA, FACS, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER, AMERICAN COLLEGE OF SURGEONS, CHICAGO, IL

Dr. TURNER. Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for inviting the American College of Surgeons to testify at this important hearing on "Bolstering Chronic Care Through Medicare Payment." The ACS and its 90,000 members remain committed to improving care for all surgical patients, including those living with chronic conditions, and to ensuring that Medicare beneficiaries receive the highest quality of care.

Quality improvement in surgery has been the cornerstone of the ACS since its founding 110 years ago, and with 13 quality programs, the ACS has set the standards for high-quality surgical care. In some cases, it has collaborated with other specialty societies to develop others. Patients seek out our programs for definitive quality measurement and evidence-based practice. We believe that medicine should be advancing toward a system that rewards

high quality and enhances the value basis of care. This transformation is underway and would benefit from efficient investments in the partnerships between CMS and subject matter experts committed to improving the way quality is measured and incentivized, and by improving the calculus of the Physician Fee Schedule.

The ACS envisions quality as a comprehensive program which centers on the patient and is inclusive of the entire team involved in providing care. Truly team-based care requires coordination with our primary care colleagues and other specialists to ensure that a patient's chronic conditions are managed appropriately to achieve the best possible outcome. This commitment to team-based care is evident in our verification programs, which include standards related to disease management. Most physicians in the current fee-for-service system, however, are evaluated on measures that do not necessarily reflect the care they deliver or the conditions they treat. Unfortunately, the current model of individual, disconnected measures is insufficient to achieve coordinated patient-centered high-value care, and provides little actionable information for continuous physician improvement or patient decision-making autonomy at point of care.

Programmatic measures developed by the ACS exhibit applicability to diverse care settings, cause a limited burden on care providers, and deliver demonstrably better results. The ACS believes that addressing the shortcomings of traditional Medicare fee-for-service payments will require new types of quality measures, facilitated by increased flexibility in the facility-based scoring option in the Merit-based Incentive Payment System.

However, Medicare cannot transform into a system which functions to reward value without immediate and lasting stability in the physician payment system. To create this stability, Congress should immediately address the payment reductions already anticipated in 2025. Under current law, it would take decades for the fee schedule conversion factor to return to adjusted 2000 levels. The implementation of positive annual updates to the conversion factor reflecting the inflation in practice costs is an essential step necessary to enhance patient access to care and to improved quality.

Yearly reductions to the Medicare conversion factor continue to be problematic for surgeons and physicians of all specialties, due to the budget-neutrality requirements for any change in the Physician Fee Schedule expected to increase expenditure by as little as \$20 million annually. This trigger amount has remained the same since its implementation in 1992. Updating the trigger for budget-neutrality adjustments would help to ensure that comparatively minor changes to the fee schedule do not always require across-the-board cuts. Congress should, at a minimum, increase the budget-neutrality trigger threshold from \$20 million to \$100 million and index it annually to account for inflation. This will create a stable base from which physicians can incorporate payment models involving risk, and will reduce unhelpful competition between specialties when other sectors of the health-care system have none of the same constraints.

Finally, Congress can do more to make alternative payment models available to physicians. Along with dozens of other specialty so-

cieties, the ACS developed and submitted proposals that were reviewed, revised, and evaluated by the Physician-Focused Payment Model Technical Advisory Committee created by MACRA. Fourteen were recommended for testing or implementation by the PTAC, but CMS has not tested any as proposed. This bottleneck has created a disincentive for stakeholder investment into the development of APMs. These innovative and value-driven proposals are some of the best ways to incorporate data into this conversation in a way that enhances patient outcomes and ultimately bends the cost curve.

Congress should require that at a minimum, some portion of the Innovation Center's budget be dedicated to testing physician- and specialist-developed APMs recommended by the PTAC. These are relatively modest reform ideas that would stabilize the Physician Fee Schedule and build upon MACRA to focus on providing high-value care to our patients.

Surgeons are devoted to their patients, and we look forward to working with you to solve these thorny problems. Thank you for the opportunity to participate, and we look forward to answering your questions.

[The prepared statement of Dr. Turner appears in the appendix.]

The CHAIRMAN. You are going to get some momentarily. Thank you.

Ms. Matthews, welcome.

STATEMENT OF MELANIE MATTHEWS, MSN, CHIEF EXECUTIVE OFFICER, PHYSICIANS OF SOUTHWEST WASHINGTON; AND PRESIDENT, MULTICARE CONNECTED CARE, OLYMPIA, WA

Ms. MATTHEWS. Thank you, Chairman Wyden, Ranking Member Crapo, and distinguished members of the committee. I appreciate this opportunity to discuss ways to enhance care for individuals with chronic conditions. My name is Melanie Matthews, and I am honored to serve as the chief executive officer, PSW, and the president of MultiCare Connected Care. I have over 2 decades of experience in health care, and have strong focus in value-based care.

PSW is an independent physician practice association formed in 1995. We participate in Accountable Care Organizations, including the Medicare Shared Savings Program and the ACO Realizing Equity, Access, and Community Health (REACH) model. Across our partnerships, we provide care to over 400,000 people in Washington, Idaho, and Oregon. Collectively, our partnerships have saved \$120 million in Medicare by maintaining an average quality score of 96 percent.

Accountable Care Organizations sit at the intersection of today's topics of both physician payment and care coordination. ACOs deliver strategies that are particularly important for individuals with chronic conditions, who frequently see numerous providers across multiple settings. To better care for populations, Congress should lean into Accountable Care Organizations, which offer the best pathway for health outcomes at a lower cost.

I would like to share three themes with you today. First, accountable care is working. It is working for patients, and it is working for Medicare. Over the past decade, ACOs have collectively saved \$22 billion. While cost savings have been a headline, the un-

derlying strategies that we deploy to achieve shared savings improve care for people.

Essentially, we wrap services around people to improve their health-care delivery experience by expanding access to care coordination and ensuring the right care at the right time in the right care setting. While we call that accountable care, you may think about that as the type of care that you would want for yourself, your family, and your community.

Second, these strategies are particularly impactful for chronically ill populations. For example, a registered nurse plays a pivotal role in the care coordination by developing and executing personalized care plans. These nurses collaborate closely with their patients, their families, and the interdisciplinary teams of physicians, social workers, pharmacists, and other health-care professionals as needed. These programs would not be possible under the fee-for-service model.

Third, we are focused on greater engagement of beneficiaries and communities. This includes providing incentives for beneficiaries such as a cost-sharing relief to increase access to services that otherwise may be avoided or foregone. An example in our ACO is, a rural critical access provider built a chronic care management program for Chronic Obstructive Pulmonary Disease. Despite the potential benefits of the program, there was low enrollment because of the beneficiary coinsurance payment. This was a hurdle. Within our ACO reach, we implemented a cost-sharing waiver to remedy the issue. This flexibility was a game-changer in increasing access and enhancing quality of life.

There are key policy levers to accelerate this transformation, including creating clear and strong incentives for participation in accountable care by extending Advanced Alternative Payment Model bonuses, strengthening the data infrastructure needed to facilitate information sharing, and simplifying and supporting provider participation in alternative payment models.

I would like to leave you with a story to help illustrate the importance of this work. Many of you know firsthand—or at least secondhand—how frightening and overwhelming it can be to be discharged from the hospital or any other post-acute care setting. Often when this happens in a fee-for-service environment, people are alone with complex instructions, and far too often this experience leads to readmissions that are preventable.

The experience is different in ACOs. We had a patient who was sent home from a skilled nursing facility with instructions for wound care. After returning home, it became clear that the health care home provider did not have the proper supplies. The patient was planning to return to the emergency department to have the wound addressed. At our ACO, the nurse care manager checked in with the patient on the phone, identified the issue, and was able to refer her to another home health provider who had the supplies and could get there immediately. The patient's experience was far superior, avoiding an unnecessary trip to the emergency department and addressing her health-care needs at home. The health-care system avoided the cost of the hospital. This is a win-win.

In conclusion, I extend my gratitude for the opportunity to share these impactful stories and advocate for advancements in health-care delivery. PSW and MultiCare Connected Care remain steadfast in our commitment to collaborate with Congress to achieve better outcomes for all patients.

Thank you.

[The prepared statement of Ms. Matthews appears in the appendix.]

The CHAIRMAN. Thank you very much. And I am going to start with you, Dr. Navathe, because I want to understand a bit more about these 50 interactions that you talked about as it related to one patient in a 3-month period. I sense what you are talking about here—and I do not want to put words in your mouth—is that if this patient was taken care of in a different kind of way, that for example, Medicare would pay every month a flat sum for this patient to a primary care doctor, that primary care doctor would coordinate things. Is that something resembling English in terms of what you are talking about here?

Dr. NAVATHE. Thank you, Senator, for the question. So, I think there are two aspects. I think the first part is, some of those 50 interactions, probably the majority honestly, would need to happen regardless. This is just a PCP, a primary care doctor, having to talk to a specialist, contact the patient, make sure that everything is translated and coordinated, and the patient is getting the right care.

The second point that you are making is absolutely right. Some portion of those interactions would probably not need to happen in a type of payment model that you are suggesting, because the primary care practice would be able to staff nurse practitioners and physician's assistants and pharmacists, and change the way that it is caring for that patient in a more effective and efficient way.

The CHAIRMAN. So, have you made a list of these interactions in terms of, say two or three different patients? I assume not in every case are there 50 interactions, but there would be different numbers, and you would see different people, and that sort of thing. But have you made a list that would be sort of a representative model?

I mean, as you know, physician payment is discussed around here like the weather. You know, everybody says, "Physician payment, oh my goodness, we have got to change it. It is not doing what we need to do. We are not spending the money effectively. We are not getting providers for this particular field and that."

So, I like your idea very much, because we have been looking—I see my colleagues, particularly Senator Stabenow and Senator Whitehouse, who have specialized in this. We have been talking about what to do about traditional Medicare for ages and ages, and in fact, the legendary *New York Times* journalist Robert Pear, who was the most authoritative reporter on health care, he did his last article on chronic care and our bill, and he had been covering it forever. And we all walked away saying, "We have to do more for traditional Medicare." And so, we want to get more details from you about how to do that with your idea of the per-month per-patient kind of payment for coordination.

There is one other question. I have a little bit of time left for the entire panel. So, apropos of that piece that Robert Pear wrote—he went through grab bars and nutritional assistance and all of this kind of stuff. What do you four experts in the field think are the lessons learned from the jump-start we had doing this for MA?

In other words, MA was better positioned at the beginning, because it already coordinated services in a constructive kind of fashion. But you cannot leave 50 percent of the elderly population behind that is using traditional Medicare.

So let's just use my time, go right down the table. What do you think the lessons are learned from the MA experience, which has produced some examples that I have given, and what can we apply to traditional Medicare now? Dr. Navathe, let us just go right down the row.

Dr. NAVATHE. Thank you, Senator. I will try to keep my comments brief. So, I think what we have learned is that there is a big gap between what traditional Medicare provides and patient needs, because Medicare Advantage plans have provided supplemental benefits like transportation. They have flexibility to reduce cost sharing. As we have heard, that can be very important.

So, I think we have to meet the patients where they are, and that has been a key lesson, right? And I think one of the big challenges is, in Medicare Advantage they have the flexibility to innovate their benefits. They have that flexibility to do some of this on their own. In traditional Medicare, there are a lot more constraints, and we need Congress to give CMS the authorities to make that happen.

The CHAIRMAN. That is way too logical for government—meet the patients where they are. Good for you.

Dr. Furr?

Dr. FURR. So, there are medical advantages of Medicare Advantage, but I will say there are also some downsides. The rise of prior authorization coincides with the rise of the Medicare Advantage plans. It is a huge hassle for our doctors trying to take care of patients. To give you an example, when I try to send a patient and I need a stress test, my nurses tell me it is easier for me to do the referral to the cardiologist than it is to get the stress test set up. I do not need to refer to the cardiologist; I just need the stress test.

It is not just tests; it is even the drugs—the change of plan, doing a different formulary. I have a diabetic who is completely controlled, hypertension is controlled. If I have to change the medication, there are some hassles with that. Medicare is much easier as far as getting services. They do not have the umbrella services. As far as getting referrals and taking care of them, there is ease there doing that.

The CHAIRMAN. Well, thank you also for mentioning the prior authorizations, because a good chunk of these talented staffers here on the podium are working on it now, because some of the stuff is outrageous, just literally outrageous.

Dr. Turner, your thoughts, lessons learned?

Dr. TURNER. Thank you for the question, Senator. I agree that there are two sides to nearly everything, and when we think about Medicare Advantage, there are some advantages. The flexibility is

encouraging. The additional burden of prior authorization can be a problem.

But when we think about innovation, that allows us to consider prehabilitation. What are the elements of that that can help patients do better with chronic conditions before their surgical procedures? We have a geriatric surgery program that allows us to think about all of the elements that can be incorporated to enhance the care of the older patient with chronic conditions. What are the elements that can be integrated into that so that their outcomes are better, so there is minimal readmission to the hospital, minimal recidivism, incorporating all of the members of the health-care team and recognizing that there is a complexity to the care of the chronic conditions of our patients that requires a holistic approach to the patient, meeting them where they are and making sure that they have the best outcome in an evidence-based fashion?

The CHAIRMAN. Great. We will wrap up with you, Ms. Matthews. I am over my time, but—

Ms. MATTHEWS. Thank you. The only thing I would add would be—

The CHAIRMAN. We want to be partial to people in the Northwest.

Ms. MATTHEWS [continuing]. Just engaging beneficiaries in their plan of care. I think there is a lot of flexibility in continuing to support those and both the alternative payment models as well as Medicare Advantage programs. Thank you.

The CHAIRMAN. Thank you.

Senator Crapo?

Senator CRAPO. Thank you, Mr. Chairman.

This will be a question for Dr. Furr and Dr. Turner. Seniors with chronic conditions can face severe access barriers, particularly for prescription medications. The Better Act, which our committee advanced unanimously this year, would help to bridge affordability gaps by dragging down out-of-pocket costs for a wide range of chronic disease treatments.

That said, clinicians and patients report record-high growth in the use of prior authorization, step therapy, and other policies that risk imposing costly burdens on providers and impeding care quality for patients. Recent studies have shown a dramatic increase in the use of these restrictions, which clinicians often cite as most pervasive in the context of medicines.

Regulations finalized earlier this year aim to streamline prior authorization timelines and processes for numerous services, but the complete exclusion of both physician-administered and pharmacy-dispensed prescription drugs seems likely to limit the effects of the final rule.

Dr. Furr and Dr. Turner, how do prior authorization and step therapy affect physicians' ability to address patient needs, and what steps should policymakers take to improve these processes?

Dr. FURR. The realization of how prior authorization started out was that it was for high-cost things, such as a PET scan or something like that. But now this has been ratcheted down. First it was procedures. Then it was things like CAT scans, and now it has gone down to drugs. And the first strange thing is, when I have a patient who is controlled with their diabetes or hypertension, we

do not need to be changing their drugs. But yet, if they move to another plan or the plan changes their formulary, they are required to change their plan.

Just to give you an example, the other day I had a diabetic who came in. I had a better diabetic drug for him that he needed, but he said, "I want this drug, which has more side effects, because I can get it for zero copay for a 90-day supply." It is a diabetic drug, but not a better drug, and not the best drug for him. But he chose that drug, because he did not want to pay a little bit more.

And just out-of-pocket costs are a huge issue. Our patients are having to decide between getting drugs and getting food. And as I mentioned the patient earlier, she was on chronic care management for 2 years, the lady with the foot. She stopped doing chronic care management because of the \$13 to \$15 copay per month, and she was no longer doing that.

Senator CRAPO. Thank you.

Dr. Turner?

Dr. TURNER. Thank you for the question. There is no question that prior authorization can create a roadblock for patients to get the evidence-based care that they need, and we are concerned about the onerous burden that it also places on the physicians, and it can delay access to care. So, one of the significant concerns is that prior authorization, which adds a tremendous administrative burden, requires lots of back and forth between the physician's office trying to get approval for what we know is the right thing to do for the patient.

The patient's care is delayed, and ultimately our goal is to provide timely and evidence-based high-quality care. So, if prior authorization creates these unreasonable burdens for the physician and the patient, it can be incredibly complex to deliver the care that we know that they deserve and they need.

So we would agree that anything that smooths that process, that allows the evidence base to be an opportunity to provide the care that we know that they need, an electronic interface that minimizes the amount of time that physicians' offices have to spend on the phone, that is time they are preparing for and seeing the next patient.

It often adds to the expense, because their practices must hire additional people whose entire job it is to stay on the phone, trying to get the care approved for their patients.

Senator CRAPO. Well, thank you.

And this question will be for you, Ms. Matthews. For many Idahoans, especially in rural communities, small physician practices provide a crucial lifeline for health-care services, from medical imaging to chronic disease treatment. Unfortunately, these providers often lack an accessible avenue to participate in Medicare's value-based care programs. MIPS in particular demands dozens of hours of administrative tasks for every participating clinician. Low Medicare patient volumes also make MIPS unworkable for many rural clinicians. According to MedPAC, roughly 460,000 remain ineligible. How could CMS or Congress help to promote participation by small rural practices in MIPS or AAPMs?

Ms. MATTHEWS. Thank you for the question, Senator. Our ACO certainly provides support and resources to critical access in rural

communities. We appreciate the opportunity that we think highly coordinated care is very likely in rural communities because everyone knows each other, and they have a little bit more opportunity to communicate among the health-care providers.

I think that stability in the program is critical to ensure that we are sending the message that this is a long-term commitment to the investments that it takes. It is complex, change is hard, and having a financial payment model that supports the financial methodologies in rural communities, many of which are based on cost-based reimbursement versus the typical fee-for-service payment, is essential.

So, it requires a little special attention for the rural communities. But in our several years of engaging with Critical Access Hospitals in smaller communities, we have felt that they have done an incredible job and are very committed to highly coordinated care.

I think I would just leave you with this, Senator Crapo. I think that value-based care is a dimmer switch and not a light switch, and I think as we get going, we need to continue to turn up the light volume on these models, and really crack the code on how to best support critical access in rural communities.

Senator CRAPO. Thank you.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Well, thank you so much, Mr. Chairman, and to you and our ranking member for all of your efforts.

We have been talking about these issues for a long time, and the importance of coordination, the importance of getting the right incentives in place, and value-based care. I remember all the discussions in the Affordable Care Act, talking about ACOs and everything. We are making steps, but we certainly have a lot more to do, as all of you are showing us, and thank you for your testimony today. I really appreciate the Bipartisan Working Group on Physician Payment Reform that we put together: Senator Thune and I, Senators Cortez Masto, Blackburn, Warner, and Barrasso. And so hopefully, working with all of you, we can make some further steps here—obviously in the right direction.

I do want to also stress though—because we talk about Medicare Advantage when we talk about traditional Medicare—Medicare Advantage plans do get paid more, and so one of the issues is, I mean, why is that happening versus traditional Medicare? I understand the flexibilities, but we built this in when we were doing—it has been there a long time—the Affordable Care Act and so on. So that is really a question. If they can do more but they are paid more, what does that say about what we should be doing here overall?

I also just wanted to mention one bill that Senator Marshall and I have. There are so many pieces of how we coordinate care and comprehensive care and deal with all the factors, all the social determinants, all the factors for people, one being food, right? Food is medicine, and Senator Marshall and I have a bill to authorize medically tailored meals under Medicare, which is important if we are talking about the health of people. Eating healthy and having access to the capacity to do that is also very, very important.

So, we have a lot to do in this area, and, Dr. Turner, I wanted to ask you a question about the Physician Fee Schedule. I mean, obviously there are a lot of challenges here that we are talking

about. But when we talk about it from a specialist standpoint, it is very important that we are looking at the front end. But from a specialist standpoint, you have spoken about the fact that support to some specialists has caused cuts to other specialists due to the conversion factor.

You have talked about this already. But could you talk more about changes to the current payment system that would support all physicians? Obviously, primary care physicians are incredibly important; so are specialists. And so, what would you recommend?

Dr. TURNER. Thank you for that question, Senator. Clearly, we are all trying to provide great care for our patients. Our primary care colleagues, surgeons, all specialists are trying to provide the best care for patients. So it is incredibly unhelpful to have the budget-neutrality trigger set so low that when an appropriate enhancement to one area comes about, it requires that some other area that may have nothing to do with the evidence base is cut.

And as we focus on value, on improvement, on evidence-based care, it really does not enhance patient care when we think about it that way. So we would favor raising the trigger for budget neutrality to the point that modest improvements and modest enhancements do not necessarily trigger that sort of intervention that requires some other specialty in an unrelated fashion to lose.

We would like to think of it as a win-win, and when we focus again on the value-based, on the evidence-based, we know for example, with our geriatric surgery verification program, that the care of the older patient is more complex, and it does require integration and a holistic approach that meets the patient with all of their comorbid factors, and allows us to provide better-quality surgical care in the continuum of care that enhances across the board.

And so, we would favor all of us benefiting by the rising tide that raises all boats, so that we can enhance the care that we are providing for the complex older patient who does have more of the comorbidities and requires a more complex approach.

Senator STABENOW. Thank you.

And, Mr. Chairman and Ranking Member, it seems to me the budget-neutrality requirement—I understand what happened, why that happened. But it does not make sense to me when we are in the context of services for people, that in order to incentivize certain services, we have to cut other services. That does not make sense to me, and so I hope we are going to really, really focus on that.

And then just very quickly, Dr. Furr, could you talk more about the alternative payment models as a way to expand quality for Medicare beneficiaries? You have talked about this, but could you speak a little bit more about that?

Dr. FURR. I think for family physicians, and particularly for rural family physicians in an underserved area, I think there are a couple of things. One, we found out in the ones we did before, that we need more time for those models to truly work. Often, those are set up for 3 to 5 years, and that is not enough time to at least show the cost savings and the difference they can make.

Two, because so many of our practices are financially in such a tough situation, there have got to be some up-front payments. You cannot, if you are just barely making a living, afford to invest in

quality that you might get later on. So, there's got to be some prospective payments that go along with it. But the time and the up-front payment are the two biggest things, and then of course the training that would go along with that.

Senator STABENOW. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Stabenow. And I know that you and Senator Thune are going to do good work with our colleagues working on this effort to look at the payment issue.

Senator Grassley?

Senator GRASSLEY. My first discussion will be with Dr. Furr and Ms. Matthews. I frequently hear from Iowans about poor access to health-care services, especially in rural areas. In many States, pharmacists, audiologists, and more are licensed and trained to perform certain medical services that Medicare does not pay for.

Example: right now pharmacists cannot get paid under Medicare Part B rules for providing wellness screenings, immunization, or diabetes management. I support modernizing Federal rules. Should modernizing Federal rules to match licensing and training laws in the various States be a part of strengthening and improving health-care outcomes for patients with chronic conditions?

Dr. FURR. Thank you, Senator. And I know you are concerned about rural areas and the importance of the geographic index also, and that we are protected there. I think that the problem in the rural areas is also, everybody is overworked, and my pharmacists are doing everything they can to fill their prescriptions. I do not know how they could even possibly consider doing wellness visits if they had that time to do that. But at this time, I mean, they are trying to do that and do immunizations. So we are all overworked, and I do not know how they could actually do that, personally.

Ms. MATTHEWS. Thank you for the question, Senator. I would just share that in the Advanced Alternative Payment Models, that we have made investments, including in the rural communities, to help support pharmacists' engagement with the patients and the providers to help support that kind of work.

Those are the kinds of things that ACOs do without a billing code, because they are responsible for the total cost of care. So, wrapping their services around, the ACOs are making investments to help bring additional access to these communities. That is inherently baked into the models.

Senator GRASSLEY. Dr. Furr and Dr. Navathe, I have championed efforts to ensure Iowa physicians, and other rural States as well, get paid fairly for health-care services. Iowans pay the same amount of money in Medicare as everyone else. So the physicians labor market is not local but national, especially with the expansion of telehealth.

Through the end of this year, Congress has established the Geographic Practice Cost Index—GPCI for short—that floor, to ensure that rural State physicians receive a fair reimbursement.

So to you two, is CMS using the more current and complete input data for GPCI to determine physicians' payments?

Dr. FURR. The AFP has strongly endorsed that and keeping that floor. The one thing we have learned from COVID is, suddenly all of my nurses decided they could be travel nurses and make two or three times what they could in rural Alabama. So now we are hav-

ing to compete with New York and California and Georgia and everywhere else. So, if they are going to come back and practice with us, they want to get the same rates. So the labor costs do not reflect, I think, what actually is going on, and inflation is the same everywhere. Our costs are just as great in our State as they are anywhere else—and in rural Iowa.

Dr. NAVATHE. Thank you, Senator, for that question. I think it is correct that the way the labor markets are functioning now is different, as Dr. Furr has highlighted, and there are needs to update the data to reflect that. There is granular data that is collected by other agencies across the U.S. Federal Government that could be used to update the input data, for example, for the GPCI, which I agree is so important.

Senator GRASSLEY. A follow-up for you, Dr. Furr. Currently, 36 States have statewide areas for GPCI and do not distinguish more urban areas within the rural States. Should there be more geographic areas to account for this?

Dr. NAVATHE. I certainly think it is important that we have the right geographic designations for us to be able to categorize the way that labor markets work and the way that individuals actually do, for example, commute from rural areas into urban areas or vice versa. And so, I think as you are highlighting, reexamining, so we are constantly up to date on how the markets function, is absolutely correct.

Senator GRASSLEY. To you too, I am going to shorten up my introduction by just asking this question. Is Medicare Advantage an effective model to expand and improve chronic care management services for seniors, while also lowering Medicare spending?

Dr. NAVATHE. So, I believe there are two sides to this. I think on one hand Medicare Advantage, which is more generously paid—you know, MedPAC for example has put out estimates that Medicare Advantage payment is up to 20 percent, maybe even more than that, more generous than the traditional Medicare program.

Those dollars are at least in part being deployed to support things like transportation, which the traditional Medicare program does not have any support for, which I can say from my own personal experience has been critical at times. Very, very important to get beneficiaries who have disabilities, for example, to their appointments. Otherwise, it can be very hard.

On the flip side, because there is such generous overpayment, if you will, to the Medicare Advantage side, it is hard to know whether we are really getting true value from all of those dollars. Certainly, there is some value in the supplemental benefits that are helping chronic disease care. But are we really getting value from it? And I would say we do not know the answer to that, and that is a very challenging question for us to wrestle with. One thing is for sure: there is no symmetry across traditional Medicare and Medicare Advantage. It is very hard for us to deliver the same kind of tailored care in traditional Medicare unless we do alternative payment models like ACO, as Ms. Matthews has highlighted.

The CHAIRMAN. The time of the gentleman has expired.

Senator JOHNSON?

Senator JOHNSON. Thank you, Mr. Chairman. First of all, thank you for this hearing. This is another one that I think is high-

lighting the fact that we have a horribly broken medical financing system, and I would argue that Medicare has not helped that. And I think the testimony today pretty well proves that, because we are talking about the payment schedule, how it has distorted medicine.

Now, I do not even want to call it a market, because I do not think we have a market in medicine anymore. And you know, I listened to Senator Stabenow—so we have been talking about this for a long time. Dr. Turner talked about innovation. I think somebody else talked about being flexible. Well, government does not really drive innovation very well. Government is not particularly flexible, and that is the problem we are all dealing with here.

So I really want to focus—I am sure you probably do not want to be practicing for 80 years, but I will take 40. I wish I could talk to a physician who was practicing 80 years ago.

But what I want to focus on, Dr. Furr, is, forget the medical innovations, which have been unbelievable, what we have been able to do in the last number of decades. I mean, what we can do in medicine is truly remarkable. But just the practice of medicine—is it better today or worse? I mean, would you like the medical innovations while being able to practice in the 1980 model? Do you know what I am trying to get at here?

Dr. FURR. It is better. I mean, years ago, we had people die out of just benign infections. We did not have penicillin—

Senator JOHNSON. But again, set aside the medical advances. Just about the practice. I mean, you are a primary care physician. We aren't able to track them very well. I mean, it seems like the solution here is a more primary-care-physician model, which we were closer to in the 1980s, probably more so in the 1950s and 1960s.

Dr. FURR. Yes. I think, we have gotten better, like you say, in advances and all, but as far as the stress of practicing, it is much more difficult now than it has ever been. Physicians used to work hard, but they spent their time taking care of patients. They do not feel like they are spending time taking care of patients now. They are doing prior authorizations and other things to get those innovations there. But there is not as much enjoyment of it.

Senator JOHNSON. And again, you are doing those authorizations because you have to do it for Medicare and Medicaid. You have to do it for insurance. You have to do it for a third-party payer system; correct?

You did not have to do that when you were actually billing the patient directly, when you had consumerism in health care, when you had patients making the decision, do I want to go to 10 different specialists, or do I really want to rely on a primary care physician, kind of let him work with me to make those decisions?

Dr. FURR. That is correct.

Senator JOHNSON. Again, the point I am making is—and I have said this, whether we are talking about our overly complex tax system or our completely broken health-care financing system—we are talking in this committee about putting a band-aid on a dying patient, and I am trying to figure out, how do we revive the patient? How do we bring back consumerism?

I often say that two areas of our economy that we are very, just habitually dissatisfied with, are education and health care. What

they have in common is, we have largely driven the benefits of free market competition out of both areas, and in particular in medicine. How do we get it back?

Again, we are not going to do it through changing the fee schedule—and, Ms. Matthews, I know you have your own little solution here. It is not a solution. It is really not fixing things. It is maybe improving things marginally.

But we are paying what, double what world health-care costs are, and we are getting, in many cases, worse outcomes. I mean, this is not working. We need a paradigm shift here. We need to think outside the box. Again, I just do not think putting a band-aid on the Medicare payment system is going to do it.

I mean, does anybody have any ideas or just want to comment on that? Dr. Turner, you look like you want to say something.

Dr. TURNER. Well, thank you for that question and for that comment, Senator. I do think that the opportunity for those closest—the subject matter experts—to propose innovative ways to provide better care and bend the cost curve, as was the plan, we think, under MIPS, is probably a good idea.

Bringing some of those good ideas that came forward through the PTAC and allowing them to actually be tested and implemented, I think, will get at part of what you are describing. One size does not fit all. Making sure that we are centering the patient and that we have the subject matter experts propose what could really be the innovation that could help to change the conversation, that is part of the solution.

And so, thinking about some of those great ideas—you know, we had one other specialty that brought forth smart, innovative, thoughtful solution-oriented ideas to the PTAC, and then they were not able to really be tested and then ultimately implemented.

So that would be one possible of the many solutions that might address what you are describing. But I agree with you entirely, that when we talk about access, and in a rural community, we have surgeons who are out there trying to keep their practice doors open who want to provide care, but the administrative burden is so onerous that in those Critical Access Hospitals, where they are the only game in town, so to speak, we want them to be able to provide the care that they want, but the administrative burden is overwhelming them.

Senator JOHNSON. And it is the administrative burden that is just a self-inflicted wound, and that is why we need to stop doing it. I would love to talk about the prospects of using AI and more expert systems in medicine. I have seen that debate over the decades, but we do not have time for that as well.

But thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague. We will be doing a lot of discussion about AI in the days ahead.

Senator Warner—we don't really do "gangs" here in the Senate Finance Committee, but to the extent we do task forces and coalitions, Senator Warner was my partner back when we got this off the ground with the late Johnny Isakson and Orrin Hatch. That was a good crowd to run with, and we welcome you.

Go ahead, please, with your questions.

Senator WARNER. Well, thank you, Mr. Chairman. You took the words right out of my mouth. I was going to actually start with a compliment to both you and the ranking member for holding this hearing, and the fact is, I do not fundamentally disagree with my friend from Wisconsin. But I do not know how, with the complexity of medicine, we reinstall this back into consumer choices, when a consumer is going to have to figure out which advertisement to believe about which promised drug or which promised therapy might work.

I do think one of the things that, again with our dear friends Johnny Isakson and Orrin Hatch—the whole notion of the CHRONIC Care Act was recognizing that some of these diseases are not going to be solved with a pill, but are going to have to be managed over a long period of time. And getting that right—I would agree with Senator Johnson that what we have done generally here—gosh, this is hard, so let's just bump up reimbursement rates across the board—is not going to be the answer as well.

I do think some of the work a lot of us on this committee have done beyond chronic care on things like telehealth, on things like getting folks to be able to get more services in the home, some of the prevention activities—we still do not have a scorecard system that scores prevention. And you know, I think about diabetes and the good work some of us have tried to do on diabetes, but that does not get recognized in any way, at least in terms of the scorecard.

But I am going to start with Dr. Furr. You know, I have spent a long, long time on advanced care planning. I have done it on Alzheimer's, and I think we are the only industrial nation in the world that has not had an adult conversation about end of life, and has not been able to sort that out in any meaningful way.

Let me be clear: I think everyone should have all the medical options available to them, but we just do not have that kind of conversation. So for years, we have been trying to get a Medicare reimbursement on advanced care planning. You know, this is a conversation we have all got to have. It is a hard conversation.

We got it in, and yet it appears to me that the take-up rate, particularly for family physicians, outside that annual wellness visit, has not really worked that well. Do you have any idea on how we—when Congress tries to set, or CMS tries to set a reimbursement schedule, that we do not so overburden it that the physicians and providers themselves just find this is too much hassle to use?

Dr. FURR. You know, I think that was a great advancement, and we do use it in our office. It means a lot to have that time to spend with the patient and look at that, and make sure they do have a plan going forward. I think the problem is, because of all the other hassles in medicine right now with the prior authorization and the other things, there are just so many hours in the day, and there are just not enough hours to do that. That does take time—

Senator WARNER. But I've got to—I want to just interrupt. I mean, if we are talking about end-of-life kind of issues or last stage—I know we are not supposed to use the politically incorrect “end of life” anymore. But who do you have to get prior authorization from, God? [Laughter.]

Dr. FURR. No, no. We do that, but—

Senator WARNER. That was just too easy. I couldn't let you get by on that one.

Dr. FURR. Yes. I mean, we do that, and we utilize that code very much. But again, there are only so many hours in the day, and your staff is doing prior authorizations. They cannot get CT scans covered. You are now forced to do all these other things that you should not have to do—

Senator WARNER. Right.

Dr. FURR [continuing]. So you cannot get to the really important things, and I think this is the problem with medicine right now. We do not have time to do the important things like you are mentioning because we have all these other hassles that really should not be there, and we cannot do them. So our time is spent doing unnecessary things, rather than doing the necessary things that you are mentioning.

Senator WARNER. Well, while I am on it—and maybe this would be for the panel because, I mentioned my mom had Alzheimer's for 11 years, 9 years of which she did not speak. My father and sister took care of her in a remarkable way. Hardest thing; I could never have done that.

But for Alzheimer's, how do we even think about reimbursement? We just, I think—FDA just recently approved another drug, \$3.5 billion, and I think drug therapy makes enormous sense. But there is a whole portion of caring.

How do we get it right in terms of chronic illness like Alzheimer's, to give the providers the right incentives to do the appropriate care, whether in-home or elsewhere, without all the hassles? Let me just go quickly down, recognizing I only have 25 seconds, and Senator Whitehouse has been very, very patient.

Dr. NAVATHE. So, I think that the short answer is, in the fee-for-service program we have to pursue alternative payment models that force the provider entity and the clinicians to internalize, balancing the health benefit with the cost. If we cannot get there, it is going to be very hard to actually steer that forward.

Senator WARNER. And that is hard to do. Very quickly, because my time has expired. But, Dr. Furr, and the balance of the panel.

Dr. FURR. And the key is, I think, for all those patients to have a family physician who coordinates their care and knows their patient, and spends time with them and their family and knows their needs. I think that makes all the difference in the world.

Senator WARNER. Dr. Turner?

Dr. TURNER. I think this is an opportunity to highlight the expansion of facility-based scoring in MIPS, to think about the type of collaborative shared accountability measures that would work for Alzheimer's and work for other chronic conditions. So, thinking about the holistic approach would address that concern.

Senator WARNER. Ms. Matthews?

Ms. MATTHEWS. I might just add that there is a new dementia care model that goes into effect July 1st of this year called the GUIDE model, and that is one of the models in which to provide additional support for Alzheimer's intervention-related care, and I applaud the work for this very vulnerable population.

Senator WARNER. And how we make sure that providers understand this and do not get intimidated by this new process is impor-

tant. I know we have another—again, I will not use the disparaging “gang,” although my first gang was with Mike Crapo on the Simpson-Bowles effort. But I do think the working group we put together on this, I look forward to trying to participate on.

The CHAIRMAN. Well, thank you, Senator Warner. Good job as always. And before you got here, I went through the history of the fact that in our original chronic care bill, as you will recall, we had major telemedicine provisions. I remember the day—I will never forget it—when Donald Trump’s head of CMS called me and asked me would it be okay if they used the bipartisan product of the Finance Committee.

I should have called you up and said, “Mark, hold a party for us,” because this was a product of the Finance Committee that really laid the foundation for expanding telemedicine during COVID. What I would like to work with you on, as you go through this task force, is expanding telemedicine, and one of the areas we ought to start with is interstate coverage. Because this idea, in this age when we talk so much about tech and AI and the like, that you cannot have patients treated when they are, you know, 10 minutes away from another place—

Senator WARNER. I do wonder who that CMS director got prior authorization from. [Laughter.]

The CHAIRMAN. That director—when the chair of the committee recovered from his shock and forgot to ask you to hold a party, it was amazing, because it was talked about again and again. Out of all the horrors of COVID—of which there are so many—one of the things that made a difference was telemedicine. I appreciate all the good work.

Okay. In the order of appearance it would be Senator Blackburn, but I know Senator Whitehouse has been waiting. Senator Lankford has been waiting.

Next in order of appearance will be Senator Blackburn.

Senator BLACKBURN. Thank you so much, Mr. Chairman. And I am glad we are talking about telehealth, because I had the legislation in the House. And I think we were all pleased when it was picked up during COVID, and we really felt its worth and its impact.

I have to tell you, in February I had the opportunity to sit down with members of the HIMSS chapter in Nashville, and as you all know, they are so focused on this bucket of issues that we are discussing today. They are innovators; they are forward thinkers.

In Nashville, our health-care industry generates, every year, \$100 billion in revenue, and it is responsible for over 500,000 jobs. So it is important, and any of my committee members or the witnesses who want to come to Nashville, we will be more than happy to set up meetings and show it off. We think it is pretty important.

But one of the things that came up in this meeting with health-care innovators and physicians was the issue of consistent reimbursement policies, and the need for that transparency for physicians and for patients and providers, and also for investors, to give them confidence. Because many of them are investing in this new innovation and new technologies, which are going to end up yielding better outcomes.

And one of the things I have witnessed in my years in the House and here in the Senate is, before we passed MACRA in 2015, we voted 17 times—17 times—to delay the pay cuts, and this was under the Sustainable Growth Rate formula. So that inconsistency, that amount of nerve-wracking, that uncertainty around compliance and being able to meet your compliance—you know, this is why I think it is so important that we look at stable physician payments as we look at MACRA. And it has been mentioned by others on the committee, we do have a working group that some of us are going to be a part of to try to find some answers to this.

I know it would make your life easier, and physicians are always talking to me about trying to cope with operational cost, and the pressure that is there. What we have seen in rural Tennessee is the closure of some practices, some early retirements, consolidations in these independent practices. And what I have noticed is, it has detrimental delays in care delivery, in wait times, and in access to affordable health care.

So, a “yes” or “no” from you all, and we will just go right down the list. I would like to know if you agree that the cost of providing care in practices has increased over the years, and if you agree that payment has kept pace with that rising cost. So “yes” or “no,” has cost increased and has payment kept pace?

Dr. NAVATHE. So, I do believe that costs have increased, particularly when you factor in inflation, and so I think that is absolutely correct.

Senator BLACKBURN. Okay.

Dr. FURR. Yes, to the first question, no to the second.

Senator BLACKBURN. Okay.

Dr. TURNER. Costs have absolutely increased, and the payment has not kept up with that. The inflation has been problematic and the reason.

Senator BLACKBURN. Okay.

Ms. MATTHEWS. I have the same answer. Costs increased.

Senator BLACKBURN. Then you all are right in line with Tennessee physicians.

I want to talk about MIPS. I know several others have talked about this. Dr. Navathe, talk to me about your experience with MIPS and the administrative burden that is there with that, and then what you see should be the changes. What lessons should we learn? What should we keep, and what should we toss?

Dr. NAVATHE. So I think the experience that my colleagues have had under MIPS has been one that, frankly, has not been that effective. So you have rightfully pointed out the operational administrative burden that comes along with that type of reporting. And it is unclear that reporting the measures that we are reporting on are actually in keeping with what beneficiaries really care about. I think that is a fundamental disconnect. I think approaches like MIPS, in general, have been shown not to be very effective in improving care.

One of the challenges getting toward what we can do is—MIPS kind of presents this choose-your-own-adventure type of approach, and that is kind of weird actually, right, in terms of trying to get a standardized set of data. I think it is very challenging to improve

MIPS, to make marginal changes to it and actually get to where we need to go.

I think most likely we need to reimagine it completely, and potentially replace it.

Senator BLACKBURN. So you would say toss it and start over?

Dr. NAVATHE. I would say replace it; that is correct.

Senator BLACKBURN. Okay; that is great.

Dr. Turner, I have a question for you I will submit, and it has to do with overestimating spending and the payment policies of the Physician Fee Schedule. So let me do that, because we need to talk about the forecast error adjustments.

But, Mr. Chairman, thank you.

The CHAIRMAN. I thank my colleague, and I am glad she is on the working group that is going to tackle these issues.

Next is Senator Whitehouse.

Senator WHITEHOUSE. Thanks very much.

I would like to talk about two pieces of legislation. One is a primary care bill that Senator Cassidy and I are working on, whose discussion draft is out and which provides for hybrid payments for primary care, and creates a physician payment expert panel to try to better organize the payment model.

Dr. Navathe, I believe you are familiar with that discussion draft?

Dr. NAVATHE. Yes, Senator, I am.

Senator WHITEHOUSE. And it seems to align quite well with your testimony before the committee today.

Dr. NAVATHE. Yes, sir. I think I would highlight two points. One, the hybrid payment model that is in the discussion draft is part of the Physician Fee Schedule. So it is not a single-model alternative payment model. I think that is very important to scalability.

The second point I would highlight is, there is a provision for establishment of an advisory committee that will not reduplicate the important work that the RUC does, but really add to it so CMS has appropriate tools to manage the fee schedule.

Senator WHITEHOUSE. And the resulting benefit if those were to become law would be—

Dr. NAVATHE. So really, two things. One, as we have talked about—Senator Wyden very nicely characterized how chronic care is such an important challenge. I think for primary care physicians, a hybrid payment could catalyze a completely new payment model at scale across the Nation.

We have talked a lot about stability here. You know, one of the challenges around alternative payment models has been that they have tended to change maybe every 5 years. It is very hard for practices to invest in something if the rules of the game are going to change 5 years later.

So the stability of what you have proposed in that discussion draft, I think, is fundamentally critical to actually getting better chronic disease care in the long run. That will necessitate adaptations to the fee schedule, and so the advisory committee really then comes in to fill in the additional needs there.

Senator WHITEHOUSE. Thank you. And let me just take a moment to thank Senator Cassidy for his work with me on that legislation.

The other bill is the Value in Health Care Act that I am doing with Senator Barrasso. Other members on this committee who are cosponsors include Senators Tillis, Cassidy, Thune, and Blackburn.

Among other things it, would extend the 5-percent incentive payment. It will help address the cost issues that ACOs face when they are trying to pay their way through a very expensive and difficult transition to treatment that is consistent with the new payment model. And I would like to ask Ms. Matthews how those incentives relate to the ability of ACOs to improve and invest in patient care?

Ms. MATTHEWS. Thank you, Senator, for the question. First, I want to thank the committee for supporting the advanced alternative payment bonuses. They are really critical at engaging the physician in ACOs, and encouraging stability and engagement.

Second, I would say that those bonuses go directly to the providers, and that allows them to make investments in care coordination and technology.

I am reminded there was a previous question around MIPS and reporting. We support independent physicians, and those incentives were paramount for engaging in AAPMs and really promoting the continuation of independent practice by helping support the investments that are critical for this transformation from fee-for-service to value.

And then also—just to make a quick comment for you, Senator Whitehouse, on the work under the hybrid—under some of these ACO models, we are testing and paying capitation to primary care. I used to say that one of the reasons I knew that we were being successful in value-based care was listening to and watching my physicians take their phone calls to manage their patients.

They were so engaged in their total care, and they were aligned around all things for their patients. So at 5, if they got a call, they said, “Come on down, let me see you,” and they were not going to the ER, as an example. They were completely accountable, and the hybrid capitation helps with that.

Senator WHITEHOUSE. It is the outcome we want.

Ms. MATTHEWS. Yes.

Senator WHITEHOUSE. My time is about to expire, so let me ask a last question for any of you who choose to comment on it for the record. So an answer in writing, so we are not burdening the time of the committee further.

We are working on a bill to, in a nutshell, require prior authorization by CMS before any prior authorizations can be applied by insurance companies to providers. They would have to really show that there is a medical justification for the prior authorization, and we would be focusing on applying that to providers that were under an alternative payment model, incentivized value-based model, and had shown that they succeeded.

So presumably, they have no interest in running up bills that would raise their costs and diminish their payment at the end of the day. It does not make sense to apply a prior authorization to a provider who is successfully engaged in an at-risk, value-based practice. And so, we are looking at trying to get rid of that, just get rid of it, and/or make them at least come in first to CMS and say, “You have to authorize me requiring prior authorization, oth-

erwise, I cannot do it at all,” and put that kind of a check on the misuse of prior authorization.

If you have any thoughts about that, I would be grateful to hear. I do think that it probably needs to focus on those who are participating in advanced payment models and have skin in the game, and have shown themselves to be successful. But I would be interested in your thoughts, and I thank the chairman.

The CHAIRMAN. I thank my colleague. And for those who are guests of the Finance Committee, Senator Whitehouse has spent an enormous amount of time over the years on these primary care issues. I have enjoyed working with him, and we look forward to doing a lot more in the days ahead.

Senator Lankford is next.

Senator LANKFORD. Mr. Chairman, thank you. Thank you all for spending your time here. A lot of things you could be doing today. Thanks for being here and being a part of it.

We have all talked about the Physician Fee Schedule and the struggle with that. That is frustrating for all of us, but especially for physicians on it. I am one of the folks who thinks we need to incentivize more doctors coming into the process, rather than the next generation of folks thinking, “I do not want to do that, to be able to deal with the hassle of that all the time.”

I would like for more folks to be able to come into the process with several things we have kind of highlighted, and I am not going to go through them as well. But the Critical Access Hospital piece has been a challenge in my State, a State that is split evenly rural and urban, and trying to be able to manage that.

We have a bill, the Rural Hospital Closure Relief Act, which gives some States some flexibilities. We have not talked about physician-owned hospitals, but that continues to be an issue long-term: allowing physician-owned hospitals to continue to be able to grow and to be able to take care of their patients.

I do want to talk a little bit about this prior authorization. Dr. Furr, you have mentioned this a couple of times as well. We have hospitals in my State that are just no longer taking Medicare Advantage because of the prior authorization issue on that. How does that get resolved? What do you see as the solution to that?

Dr. FURR. And you are seeing physicians refusing to take them, along with that, and it is a huge hassle. It takes a huge amount of time. I think physicians need to be able to practice. And again, when it is for big-budget items, I do not have a problem with prior authorization, but when it comes to basic drugs and basic things we need to do—

Just to give you a perfect example, if I have a patient with an acute abdomen, it is easier to send them to the emergency room—because they do not have to get a prior authorization to do their CT scan—than for me to do it in my office because it could take me a day or 2 to get that done.

So the prior authorizations, which are meant to control costs, in many ways are actually increasing cost. And sometimes the best drug might be a more expensive drug, but it is better for the patient because it might lower their cardiovascular risk, along with taking care of their diabetes or their hypertension.

So those are all issues with prior authorization that keep us from providing the best care that we can, and actually drive up cost.

Senator LANKFORD. Okay. That is helpful to be able to get context.

Ms. Matthews, you have talked a lot about the value-based care, and some of the issues and the innovations that are there. With 34 ACOs that are operating in Oklahoma, they have saved \$50 million, the best we can guess, the last couple of years on it.

But I do want to give an example of this. We have one ACO in Oklahoma that saved almost \$9 million just in 2022. But they missed the minimum savings rate by .17 percent. So here is the challenge. What recommendations would you make on making changes to the Shared Savings Plan to make sure that we have more ACOs and that we do not actually frustrate entities that are trying to get into this?

Ms. MATTHEWS. I think building in the stability for the long-term commitment to the AAPM, and engaging with CMS and Congress on the importance of accuracy around benchmarking. You know we had, through COVID, very, very different utilization patterns, and those were realized very differently depending on the State that you lived in as well.

And so, when we look at creating national and regional benchmarks, there is some implication in the benchmarks from COVID, just because of the utilization and historical expenditures. So that certainly created some of those methodologies.

The other thing is, we are learning so much, and so I applaud the work that we are doing to take a look at what we called the lessons learned in the models, and how do we continue to iterate on those to be more successful for the models in the future.

Senator LANKFORD. Okay.

I want to ask about something that we have not talked a lot about today, and that is hospice care and how it interacts with Medicare, just for the care of patients and individuals. I know that it is set up typically for the last 6 months of life; not always. We have a rather famous example of that in President Carter, who I think has been in hospice care 14 months at this point or approaching that. The design of it is to be able to help with end of life, to be able to help through not only families, to increase some benefits in some areas and decrease them in others.

I walked through this recently. I will not go through all the story on this with my own mom, who was a Parkinson's patient for years. She passed away a year and a half ago. But some physicians toward the end would talk to me about hospice care and were walking through that as a son and a mom and a physician.

I was advised, well, you know what? If hospice care is not working out and you want to come see a specialist or whatever it may be, you can just drop it, go back into Medicare, be in Medicare for a while, then drop that, go back into hospice care. I suddenly understood there is loophole in the system that is literally being built in, and it is being exploited. I personally watched firsthand in that, other issues that are like that.

What would you recommend on changes in hospice care and ways that we can help families in those moments, whether that be in the

value of it or what needs to be done do be able to improve hospice? I am open to anyone who wants to contribute.

Dr. NAVATHE. I am happy to contribute. Thank you so much for the question.

So I think a couple of things to highlight here. I think first, one thing that is actually quite interesting is another Federal program. The Veterans Health Administration provides a benefit to veterans where, when they opt into hospice, they actually do not have to forego regular life-extending care.

And I believe the latest estimate from the VA is that that is a cost-saving program for them still, because it allows palliative care clinicians to come and educate patients and align care with their preferences, without what might seem to a family or a patient as a somewhat draconian thing, which is, I have to walk away from opportunities for other care. So that is one thing to contemplate.

The other thing is, our hospice payment system also has opportunities for improvement. There are some peculiar incentives, in that we have caps on sort of duration of care that hospices can give. Those create distortions. So it is unclear that those caps are actually doing well for our beneficiaries, and that is something else that could be contemplated.

Senator LANKFORD. Thank you for that.

The CHAIRMAN. And the time of my colleague has expired.

Senator Warren?

Senator WARREN. Thank you, Mr. Chairman.

Physicians' practices are increasingly being gobbled up by corporations and Wall Street. Today, nearly three out of four physicians work for a hospital or a corporate owner rather than for themselves. In between 2012 and 2021, private-equity buyouts of physician groups increased over 500 percent. And it's not just private equity. Insurance companies like UnitedHealth, giant retailers like Amazon, and investor-backed groups have all dramatically expanded their control over physician practices.

Here is one to look at. The total capital raised for private investment in primary care alone increased by over 1,000-fold in just a decade. It went from \$15 million—with an "m"—in 2010 to \$16 billion—with a "b"—in 2021. This is an alarming trend, and corporate consolidation of health care can increase costs, it can lower the quality of care, and it can accelerate physician burnout. But to reverse the trend, we need first to understand what is motivating physicians to sell their practices.

So, Dr. Furr, you are the president of the American Academy of Family Physicians. Why do you think independent private physicians are increasingly willing to sell their practices and work for a big corporation?

Dr. FURR. Thank you, Senator, and I do not think it is their first choice. Physicians tend to be independent-minded, and when I first had a practice 40 years ago, most of us did go into practice for ourselves.

The cost of practice has just become overwhelming. It started with the emergence of the EHRs and the amount of cost that went into that, and even though there was some reimbursement for that, it was still a cost expense. Now the cost of running your practice—what you have to pay for your staff to have good staff, what you

have to pay to do all the prior authorizations and all the other hassles that go along with that—the cost has just become enormous. And then, you have something like the Change Healthcare attack, where you suddenly do not get payments for 6 weeks and you are having to take money out of your bank account to fund your practice. And of course, if you are an independent physician, what happens is, you pay everybody else, and the way you make up the difference is, you do not take any pay.

Senator WARREN. So you are telling me it is about the economics of this?

Dr. FURR. Yes.

Senator WARREN. And——

Dr. FURR. And the complexity of the system.

Senator WARREN. And the complexity of the system. But that is a part of the economics too, right?

Dr. FURR. Yes, it is.

Senator WARREN. So let's take a look at the Medicare part of this. Seniors, people with disabilities, rely on Medicare Part B to cover their doctor's office visits and other physician services. But Medicare payment rates, for primary care physicians in particular, are basically too low to cover their costs.

Medicare payment rates are set through what is known as the Physician Fee Schedule, which determines how much Medicare will reimburse a doctor for, say providing a routine check-up or performing knee surgery. The payment rate is determined in large part by the "relative value assigned to it."

A secretive committee run by the American Medical Association has played an out-sized role in recommending the relative values of physician services, and it has overwhelmingly recommended that specialty services are worth a whole lot more than primary care.

So, Dr. Navathe, can you explain why this committee over-values specialty services?

Dr. NAVATHE. The methodology the committee uses very much heavily values inputs like time, differentiated skill, intensity—and these are easier to estimate for concrete things like doing a surgical procedure, more so than they are for a cognitive activity like diagnosing a patient effectively.

Senator WARREN. So that is interesting. So let me ask: the committee itself for the AMA, is it dominated by specialists?

Dr. NAVATHE. I believe there is an overrepresentation of specialists relative to primary care, yes.

Senator WARREN. Well, the reason I ask about this is, many organizations, including the National Academy of Medicine and the GAO, have called for changes in structure, so that primary care is adequately paid. I strongly agree with them, and so I think this is a part of what we have to understand about why physicians feel forced to sell their practices.

There is another reason, though, why primary care physicians have been motivated to sell their practices, and it is the growing administrative burdens that you talked about earlier, Dr. Furr, where doctors are spending more time doing paperwork and less time with patients, which has widened the gap between primary care physicians and their Medicare patients even more.

Now, we know that the number of independent physicians who have chosen to sell their practices appears to have significantly grown over the last 10 to 15 years. Dr. Furr, what changed during that time period to make the administrative burden so much worse?

Dr. FURR. As I mentioned earlier, one of the things is, more of them are covered by Medicare Advantage plans, which have a lot of prior authorization, even on drugs now, that we used to not have to deal with—

Senator WARREN. Okay. So prior authorization is part of it. Anything more?

Dr. FURR. The prior authorizations, and then just even admissions to the hospital, things like that. All of those have to be prior authorized procedures—all of those things. And then the complexity of coding continues to get more and more complex, and so then you have to do additional codes, and if you do not do one little thing, and you code it wrong, that code gets kicked out.

Then your claim gets rejected, and you have to resubmit again, and there is just all that continual cost of doing that.

Senator WARREN. So, I had a doctor tell me last week, after we had done a hearing, that it is now the case that you cannot just do an animal bite as your code, that there is a different code for a turtle bite, as opposed to a fish bite. And so, we want to watch out for this going forward, right?

Look, my view is, we should reward high-quality care rather than high-volume care. But to do this requires significant up-front investments that existing payment rates for primary care just do not cover. And I think this has created the perfect environment for corporate investors to swoop in.

There are things we can do to make physicians less vulnerable to corporate vultures. As this committee continues to work on physician payment reform, it is critical that we root out the conflicts of interest that assign more value to specialist services than to primary care. But we must also ensure that the transition to value-based care does not lead to further consolidation and further corporatization.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague for her remarks. Those were very important issues. I am not going to get into all of the animal species, but my colleague is making the key point, which is, we have to stop the financial vultures. And one of the things that I am going to do—and I look forward to working with my colleague on the whole suite of issues she just went into—is, we touched on it earlier, the \$6 billion that goes for marketing.

I think that money can be spent in a better place, and we are going to be talking to these nice four witnesses, and our working group, and the like, about whether we can find some common ground on putting that money, as Senator Warren is talking about, into patient care. Because right now, as she just described, patients and taxpayers—because it is two sides of one coin—are getting fleeced. So let me just offer a quick comment, and we will be out the door.

At one point, I think one of our colleagues talked about, well, is this going to be another band-aid on Medicare? No. What we want

to do is fundamental change. When we recognize that Medicare has changed, that it is not just about a broken ankle, it is about chronic care—and, Senator Warren, I think you might not have been able to be here because it has been such a busy day.

Dr. Navathe talked about 50 interactions for a particular patient with all of these different kinds of people. And what you are talking about is primary care and particularly focusing on these chronic illnesses and patients rather than just propping up the vultures. And what we began in 2018, when Chairman Hatch was in charge of this committee, was CHRONIC Care 1.0.

We have gotten good advice today about how to start closing the gap between Medicare Advantage and traditional Medicare. That is urgent business. And we certainly heard a lot about reducing administrative hassles and letting doctors put their time into patients rather than filling out forms and going through all these bureaucratic hoops.

So this has been a good hearing of the Finance Committee. This is about the future of Medicare. We started it in this committee, and this is now moving to CHRONIC Care 2.0, and getting more to patients and protecting taxpayers and not all these rip-offs that Senator Warren just appropriately described.

With that, the committee is adjourned.

[Whereupon, at 11:52 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MIKE CRAPO,
A U.S. SENATOR FROM IDAHO

Across the country, more than 60 million Americans rely on Medicare to meet their health-care needs. Over the next decade, this population will grow by more than 20 percent. Medicare's coverage and payment policies play a dominant role in setting benchmarks and baseline rules of the road not just for the program itself, but also for countless other payers, affecting hundreds of millions of working families.

In short, ensuring a resilient and robust Medicare program has become more vital than ever. Unfortunately, our current policies seem poised to fall short of that goal.

Today's hearing highlights the urgency of advancing durable clinician payment reforms—both for front-line medical providers and, more importantly, for patients. In the absence of proactive policy changes, tens of millions of seniors will suffer the consequences. The risks of inaction range from surges in wait times and delays—including for critical care—to clinician office closures and cutbacks in provider participation. Our committee has an obligation to strengthen the Medicare program and avert these unacceptable outcomes.

A successful legislative initiative must reckon with a range of challenges under the current paradigm, which has served to devalue and distort payments for vital services, as well as to exacerbate administrative burdens. In inflation-adjusted terms, Medicare Physician Fee Schedule payments have declined by more than 25 percent over the past 2 decades, even as clinicians continue to face skyrocketing costs for overhead, equipment, supplies, and staffing needs.

As the Medicare trustees cautioned last year, the colossal gap between stagnant fees and steep inflation poses a dire threat to long-term patient access. The current conversion factor update schedule cannot sustain an effective—or even adequate—clinical workforce moving forward.

For many specialists, recent regulatory changes have further intensified these issues, as new billing codes and valuation shifts have triggered drastic cuts under the program's budget-neutrality rules. Based on inflexible cost-containment measures, a payment bump for primary care prompts payment reductions for entirely unrelated procedures and services, from brain surgery to advanced cancer care.

From 2014 to 2023, for instance, even before adjusting for inflation, the fees for chemotherapy administration and IV infusions declined. Under these conditions, it should come as no surprise that many physicians have opted to sell their practices, join health systems, or limit new Medicare patients. Structural fee schedule reforms should shift away from the status quo, which forces clinicians to vie for ever-dwindling resources, and move toward models that promote and reward team-based, patient-centered approaches.

Nine years ago, Congress took concerted action to repeal the draconian Sustainable Growth Rate (SGR) system, which had threatened cascades of dramatic cuts. In enacting the Medicare Access and CHIP Reauthorization Act (MACRA), policymakers sought to stabilize the fee schedule and incentivize value-based care.

In practice, these reforms have largely failed. The Merit-based Incentive Payment System aimed to establish an accessible on-ramp to participation in quality-driven alternative payment models, or APMs. Instead, this system has buried clinicians in

dozens of hours of paperwork each year, all in exchange for potential, marginal payment bumps, based on ambiguous metrics that lack meaningful value for patients.

A number of primary-care-focused APMs have shown promise, but countless specialties lack access to any clinically relevant models at all. While the MACRA-established committee to translate clinician-developed APM concepts into concrete policy options has worked through dozens of viable proposals, the Centers for Medicare and Medicaid Services (CMS) has largely rejected these opportunities.

Reforms to advance value-based care thus demand a focus not just on financial incentives, but also on structural improvements that ensure meaningful options, informed by clinical experience and aligned with patient needs. I look forward to building on this committee's bipartisan work to bolster and modernize our clinician payment systems. The program's current and future enrollees depend on it.

Thank you to our witnesses for being here today, and thank you, Mr. Chairman.

PREPARED STATEMENT OF STEVEN P. FURR, M.D., FAAFP,
PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Chairman Wyden, Ranking Member Crapo, and distinguished members of the committee, thank you for the opportunity to testify today. My name is Steven Furr, M.D., FAAFP, and I am a practicing family physician from Jackson, AL. I am a co-founder of Family Medical Clinic of Jackson, a rural health clinic, a member of the medical staff of a small rural hospital, and medical director of the local nursing home. As the President of the American Academy of Family Physicians (AAFP), I am honored to be here today representing the more than 130,000 physician and student members of the AAFP.

As a family medicine specialist who has cared for patients for more than 35 years, I can speak firsthand about how fee-for-service payment in traditional Medicare, including its underinvestment in primary care and associated administrative burden, are impeding the delivery of high-quality, patient-centered, comprehensive primary care, which encompasses chronic care management (CCM).

Family physicians provide continuing and comprehensive medical care, health maintenance and preventive services to patients across the lifespan regardless of age, gender, or type of problem. Through enduring partnerships, family physicians help patients prevent, understand, and manage illness; navigate the health system; and set health goals. The defining features of primary care, including continuity, coordination, and comprehensiveness, mean family physicians are particularly well-suited to serve as the focal point of care for patients with chronic conditions.

Nearly 95 percent of adults 60 years and older have at least one chronic condition, and nearly 80 percent have two or more.¹ This is only projected to get worse in the coming years as the number of adults 50 years and older with at least one chronic disease is estimated to increase by almost 100 percent from 71.522 million in 2020 to 142.66 million by 2050.² Effectively meeting the current and future needs of our patients with chronic conditions requires our Nation to better leverage primary care as the foundation of our health-care system. **However, our current fee-for-service payment structure favors and incentivizes work that is done to a patient, rather than done with and for them.** We need doctors who care for people, not doctors to deliver services.

I'm seeing how our failure to invest in and uplift the true value of primary care is impacting my patients every day. Our physician workforce skews heavily toward non-primary care specialists, and we have fewer primary care physicians relative to the population than in other countries. This is having severe impacts on patient access. In a recent comparison of primary care access across 10 peer countries, U.S. adults were the least likely (43 percent) to have a longstanding relationship with a primary care provider and a growing number of adults have reported not having

¹National Council on Aging. Chronic Inequities: Measuring Disease Cost Burden Among Older Adults in the U.S. A Health and Retirement Study Analysis. Page 5, Figure 2. April 2022. Accessed online at: <https://ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults>.

²Ansah JP, Chiu CT. Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Front Public Health*. 2023 January 13;10:1082183. doi: 10.3389/fpubh.2022.1082183. PMID: 36711415; PMCID: PMC9881650.

any usual source of care over the past decade.³ At the same time, three-quarters of U.S. adults (73 percent) say the health-care system is not meeting their needs.⁴ This data is telling. People are losing their trusted relationship with a primary care physician and, in turn, their trust in the health-care system.

Evidence continues to suggest this type of longitudinal relationship that I and other primary care physicians foster with our patients leads to better control of chronic conditions, fewer emergency department visits and hospital stays, and improved health outcomes.^{5,6} Unfortunately, traditional Medicare underinvests in these trusted relationships with patients. Low primary care payment rates in a system that rewards volume over value means physicians are pressured to see as many patients as possible. Meanwhile, overwhelming administrative burden takes time away from delivering patient care and often requires physicians to spend hours outside of the office doing documentation.

These factors are leading current primary care physicians to leave the field and, when combined with the burden of student loan debt, dissuading medical students from pursuing primary care specialties like family medicine. At a time when Americans have more chronic conditions than ever, we should be making strides to embed primary care physicians in every community. Instead, we've created a policy framework that is actively driving prospective physicians away from primary care and perpetuating nationwide workforce shortages.

Decades of systemic underinvestment in primary care and prevention have led to poorer population health and a greater emphasis on rescue medical care, rather than health care. We as a Nation have worried about increased up-front spending and implemented policies that have wrongly steered people away from high-value, low-cost services like preventive screenings and primary care office visits. **By failing to invest more up-front dollars in primary care, we're paying an even higher price.** We're spending more than ever on health-care costs, both as a Nation and as consumers, because we have sicker patients receiving later diagnoses and utilizing expensive settings like the emergency room and hospital as their "usual source of care."

Establishing a health-care system that prioritizes primary care will, among many other things, require a meaningful overhaul of physician payment that will take time. However, as a starting point, I urge Congress to consider policies that work toward the following objectives:

- More appropriately valuing the work of primary care within the Medicare Physician Fee Schedule, which is the framework for many value-based payment arrangements;
- Reforming budget neutrality requirements that unnecessarily pit physician specialties against one another while undermining CMS's ability to invest in *all* the services a patient may need;
- Addressing existing financial barriers that dissuade patients' utilization of chronic care management and other primary care services by waiving cost sharing responsibilities; and
- Providing primary care physicians and practices with more prospective, sustainable revenue streams that allow them to tailor the care they deliver to their patient's needs.

Reforming Fee-for-Service to Better Value Primary Care

As noted in my introduction, access to longitudinal, coordinated primary care—which family physicians like me provide every day—has been shown to increase utilization of preventive care, improve outcomes for patients with chronic conditions, and reduce costly emergency visits, hospitalizations, and unnecessary specialty out-

³Gumas ED, et al. "Finger on the Pulse: The State of Primary Care in the U.S. and Nine Other Countries," March 28, 2024. The Commonwealth Fund. Accessed online at: <https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/finger-on-pulse-primary-care-us-nine-countries>.

⁴The Harris Poll, "The Patient Experience: Perspectives on Today's Healthcare." 2023. Accessed online at: <https://www.aapa.org/download/113513/tmstv=1684243672>.

⁵Jennifer Arnold, "Fostering Long-Term Doctor-Patient Relationships to Improve Outcomes," Duke Health, January 17, 2017.

⁶Cabana MD, Jee SH. Does continuity of care improve patient outcomes? J Fam Pract. 2004 December;53(12):974–80. PMID: 15581440.

patient visits. Yet the United States has continuously underinvested in primary care with only 5 to 7 percent of total health-care spending going to primary care.⁷

Last month, the AAFP's Robert Graham Center, in collaboration with the Milbank Memorial Fund and the Physicians Foundation, released the Nation's second primary care scorecard, which reported that national spending on primary care decreased from 6.2 percent in 2013 to 4.7 percent in 2021. Primary care spending decreased for all payers between 2019 and 2021 with Medicare being the most pronounced with a 15 percent drop.⁸ While some of this decrease could be due to a drop in office visits during the pandemic, it is a trend worth noting.

The impact of this long-term underinvestment is evidenced in our Nation's health. When we look at health outcomes across the world, we're not doing well by almost any measure. Compared to other high-income, peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.⁹ A common theme across countries with better health outcomes and lower health-care costs is that they invest more in their primary care system with estimates placing primary care spending between 12 and 17 percent of total health-care spending for these high-performing nations.¹⁰

One of the major factors contributing to this underinvestment is the relative undervaluation of primary care in fee-for-service (FFS), the predominant payment model. In general, the Medicare Physician Fee Schedule (MPFS) values procedural services delivered by other specialists higher than it does office visits and other cognitive services, which are most delivered by primary care physicians. Primary care and other cognitive services have been passively devalued over time as many new procedural codes with higher values have been added.¹¹

This devaluation has led to lower compensation for primary care physicians who specialize in treating the whole person compared to our specialist peers, despite the vital role we play in managing chronic conditions and coordinating patient care across a large team and despite the fact evidence has shown that primary care office/outpatient evaluation and management (E/M) visits are more complex and comprehensive than those delivered by other specialties.¹² This devaluation is not limited to Medicare. Many other private and public payers peg their payment rates to the MPFS rates or use the relative values in the MPFS to set their rates.

FFS doesn't just underinvest in primary care—it also makes it extremely complex to get paid. We must submit unique codes for each and every service we provide—documenting both what we did and why we did it. This is incompatible with the continuous, comprehensive nature of primary care which spans everything from basic preventive services to more complex services involving chronic care management, integrated behavioral health, and care coordination. For patients with chronic conditions, these discrete services may include patient education, care planning, and managing medications, all of which are ongoing and continuous processes. Each of these services must be individually documented to justify payment for typical, comprehensive primary care, even though these services are all foundational aspects. Billing for primary care under FFS is like trying to cut a roll of paper with a hole punch rather than a pair of scissors.

The retrospective, volume-based nature of FFS also fails to account for the costs of longitudinally managing patients' overall health. It does not provide practices with the time and flexibility to invest in the care management staff and population health tools that enable practices to efficiently and effectively meet patients' individual evolving health needs. For example, FFS structures have not historically paid for wraparound patient activities, such as community health workers or care coordi-

⁷Jabbarpour Y, Greiner A, Jetty A, et al. Investing in Primary Care: A State-Level Analysis. Patient-Centered Primary Care Collaborative and the Robert Graham Center; July 2019.

⁸Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. The Health of U.S. Primary Care: 2024 Scorecard Report—No One Can See You Now. The Milbank Memorial Fund and The Physicians Foundation. February 28, 2024.

⁹Turner A, Miller G, and Lowry E. "High U.S. Health Care Spending: Where Is It All Going?," The Commonwealth Fund. Published October 4, 2023. Available online at: <https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going>.

¹⁰Baillieu R, Kidd M, Phillips R, et al. The Primary Care Spend Model: A systems approach to measuring investment in primary care. *BMJ Global Health* 2019;4:e001601.

¹¹Linzer M, Bitton A, Tu SP, et al. The End of the 15–20 Minute Primary Care Visit. *J Gen Intern Med*. 2015;30(11):1584–1586. doi:10.1007/s11606-015-3341-3.

¹²Katerndahl D, Wood R, Jaén CR. Complexity of ambulatory care across disciplines. *Healthcare*. 2015, Available at: <https://doi.org/10.1016/j.hjdsi.2015.02.002>.

nation, but these interventions enable family physicians to better address a patient's identified health-related social needs (HRSNs) within a patient's community context. This disadvantages patients who require more support and the physicians who care for them. While Medicare has implemented new codes for some of these services in 2024, such as community health integration and social drivers of health risk assessments, their utilization and effectiveness is not yet known.

For these reasons, the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care. We strongly believe well-designed APMs provide primary care a path out of the undervalued and overly burdensome FFS payment system that exists today, and in turn will better enable the Medicare program to meet the needs of its growing and aging beneficiary population in new and innovative ways. Unfortunately, a dearth of primary care APMs and the inadequacy of FFS payment rates that often underlie APMs are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is one essential strategy to support physicians' transition into value-based care.

Therefore, while FFS is not the future the AAFP envisions for primary care, it is the present. Federal policymakers must ensure the current FFS system appropriately and sustainably compensates primary care physicians to make more meaningful progress toward the future—one that rewards value over volume of services.

We have been encouraged by recent regulatory policy changes aimed at more appropriately valuing and paying for primary care and other types of cognitive care in Medicare. The AAFP greatly appreciates that CMS finalized and Congress supported implementation of the G2211 add-on code in 2024, which can be billed alongside office visits that are part of an ongoing, longitudinal care relationship. G2211 is an incremental but meaningful step in appropriately valuing primary care and supporting longitudinal, holistic patient-physician relationships, relative to other services in the fee schedule.

However, the zero-sum, budget-neutral nature of the MPFS is undermining investments like G2211. Existing budget neutrality requirements force CMS to offset increases or additions anywhere in the MPFS with across-the-board cuts to *all* services in the MPFS, including those most delivered by primary care physicians. In short, this means Medicare cannot appropriately pay for all the services a patient might need, and it perpetuates inequities in the fee schedule, which bleed into and impact the success of primary care practices in VBP arrangements and outside of Medicare.

For these reasons, the Academy has long called for reforms to budget-neutrality requirements, which are unnecessarily pitting physician specialties against one another. We strongly urge the committee to consider proposals such as increasing the current budget neutrality threshold, which has not been updated since the fee schedule was created in 1992, correcting the impact of over- or under-utilization assumptions by CMS on the availability of funds, and more regularly updating the direct costs used to calculate practice expense Relative Value Units (RVUs). I'd also like to raise the suggestion that Federal policymakers should think of budget neutrality in broader terms than it currently is. As I've discussed, proper investment in primary care yields the potential to increase long-term cost savings through outcomes such as reduced emergency department visits, hospitalizations, and better management of chronic conditions. I would make the case that those savings should be considered as part of the direct budgetary impacts of increasing primary care investments in Medicare.

In terms of other opportunities to improve CCM in traditional Medicare, I'd like to discuss the experience of family physicians and their patients in utilizing some of the CCM codes. In 2015, Medicare began paying physicians for delivering non-face-to-face CCM through separate codes. Being able to bill for CCM has been an overall positive experience for our practice. However, there remain some operational challenges such as patient cost-sharing requirements that are limiting uptake by patients who would truly benefit from this type of additional support. A 2022 study found that MPFS billing codes for preventive medicine and care management services are being underutilized even though primary care physicians were providing

code-appropriate services to many patients. The median use of the preventive and care coordination billing codes was 2.3 percent among eligible patients.¹³

I've had patients in my practice opt out of receiving these services simply because the \$15 or so a month they faced in cost-sharing was not financially feasible. In almost every case these were the very patients that would most benefit from CCM. This rings true for many of the other new codes Medicare has implemented, including G2211, SDOH risk assessments, and community health integration services. Patients are not used to paying for these services and, understandably, are likely to be resistant to doing so. If we want to incentivize usage of these high-value services, we must waive patient cost-sharing.

In many ways, CCM is a preventive service in that it reduces emergency department and other outpatient visits. Removing cost sharing for CCM and other primary care services increases access to these services without increasing overall health care spending.¹⁴ The available evidence indicates that reducing or removing cost barriers to primary care increases utilization of preventive and other recommended primary care services, which improves both individual beneficiary and population health. For example, while cost sharing for most preventive services is waived across payers, many patients don't access all the preventive care recommended for them because they don't know what is or isn't covered or they are concerned they might be charged for raising other health issues in the same visit.

Therefore, the AAFP supports the Chronic Care Management Improvement Act (H.R. 2829), which would waive patient cost sharing for the CCM codes under traditional Medicare. We urge Congress to pass this and other legislation to remove cost-sharing barriers to other primary care services.

Supporting the Transition to Primary Care Value-Based Payment

Alternative payment models (APMs), when well-designed and implemented to meaningfully support primary care, provide practices with predictable, stable revenue streams that afford them the funding and flexibility needed to build teams and implement technology and infrastructure to deliver high-quality, patient-centered care—without the administrative complexity of FFS.

Value-based payment (VBP) arrangements, such as population-based payments or Accountable Care Organizations (ACOs), better support and encourage physicians to deliver a more comprehensive set of services, such as care coordination and addressing HRSN, through prospective payment and flexibility. These types of arrangements invest in the longitudinal, continuous relationships primary care physicians have with their patients in ways that FFS has not historically and enable practices to tailor their care to better support patients with chronic conditions while improving related health outcomes. For example, practices might host monthly diabetes group visits to improve A1C. The frequent touches and support from these group visits can lead to better health outcomes for patients with type 2 diabetes and help the practice meet quality measure requirements.

In the Comprehensive Primary Care Plus (CPC+) model tested by the Center for Medicare and Medicaid Innovation, participating practices reported they used the model's prospective payments to invest in care delivery transformation that would not have been possible if FFS was their only source of revenue. Some of these transformations included key CCM activities, such as: providing patients with after-hours access to a physician or other clinical staff member who has real-time access to the practice's EHR; using designated care managers, typically onsite staff who are nurses or medical assistants, to deliver longitudinal care management services; and co-location of a pharmacist at the practice site to support comprehensive medication management. To be clear, the primary difference that afforded practices the opportunity to make these investments is that the payment was *prospective*; while they are possible to make in FFS, the retrospective payment makes it much more challenging for practices to do so.

Given these and other benefits, there is mounting multistakeholder, cross-industry support for a primary care payment system that rewards value and holds promise for improving health, addressing disparities, and slowing the overall growth

¹³ Sumit D. Agarwal, Sanjay Basu, Bruce E. Landon The Underuse of Medicare's Prevention and Coordination Codes in Primary Care: A Cross-Sectional and Modeling Study. *Ann Intern Med*. 2022;175:1100–1108. [Epub 28 June 2022]. doi:10.7326/M21-4770.

¹⁴ Ma Q, Sywestrzak G, Oza M, Garneau L, DeVries A. "Evaluation of Value-Based Insurance Design for Primary Care." (2019). *The American Journal of Managed Care*. 25: 5. <https://www.ajmc.com/view/evaluation-of-valuebased-insurance-design-for-primary-care>.

of health-care costs. Federal policymakers should increase participation opportunities in primary care models that align with the AAFP's guiding principles for VBP and meet practices where they are, allowing them to gain a foothold in and stay in VBP.

Congress tried to provide an on-ramp for more practices to participate in APMs with the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) and implementation of the Merit-based Incentive Payment System (MIPS), which was intended to provide clinicians with experience being measured on their performance. The AAFP supported the intent of fostering continuous performance improvements that lead to better outcomes for patients. Unfortunately, continuous cuts to Medicare FFS payments have inhibited most practices from making the necessary investments that would allow them to successfully move into APMs. Further, the current design of MIPS, which focuses on individual clinician performance using largely process rather than outcomes measures, does not appear to be driving care improvements as much as it is adding administrative complexities that detract from patient care while unfairly penalizing small and rural practices.

MACRA requires CMS to apply payment adjustments to Medicare Part B FFS payments based on an eligible clinician's (EC) performance in MIPS. Clinicians with a MIPS final score above the performance threshold receive a positive adjustment while those below the threshold receive a negative adjustment. The adjustments must be budget neutral—meaning the total value of annual positive adjustments are equal to the total value of negative adjustments. As such, both the positive and negative adjustments are made on a sliding scale with the exception that those in the bottom quartile automatically receive the maximum penalty for the year.

While most physicians have met or exceeded the MIPS performance threshold in past performance years, physicians in small and rural practices consistently have lower than average MIPS scores. As the performance threshold increases, it will become more difficult for small and rural practices to avoid a negative payment adjustment, which can be up to 9 percent to their Medicare Part B services. Given these challenges, I urge Congress to consider reforms to the MIPS program to alleviate the administrative costs of reporting to the program, ensure it drives meaningful quality improvement, and assist physician practices in building the necessary competencies to transition into alternative payment models.

Congressional action is also needed to ensure Federal policies provide appropriate support and incentives to physician practices moving into APMs. I appreciate that Congress passed legislation last month to extend the advanced APM (AAPM) incentive payment through performance year 2024, albeit at a lower amount.

These payments have served as an important tool for attracting physicians to participate in AAPMs, which require significant up-front (and often ongoing) investments in new staff, technology, and other practice improvements. Primary care practices have also used the AAPM bonus payments to offset the cost of investing in care delivery transformation that drives success in these models by improving patient outcomes and lowering spending. Expiration of the AAPM incentive payment could institute an additional barrier to continued AAPM participation for physician practices and further impede family physicians' ability to transition value-based payment models.

Congress should also consider legislation to provide CMS with authority to modify AAPM qualifying participant thresholds to ensure independent practices are not left behind. The Value in Health Care Act (S. 3503), which the AAFP has endorsed, is one piece of legislation that would do so.

However, primary care physicians still face significant barriers to entering and sustaining participation in VBP arrangements, even when they align with AAFP's principles. Practices must comply with an ever-increasing number of Federal and State regulations, negotiate contracts with multiple payers, acquire and effectively aggregate and analyze data to track patient utilization, treatment adherence, and identify outstanding needs—all while doing our primary job of taking care of patients. This creates an immediate and high barrier to entry, particularly for independent practices that don't have the up-front capital or resources.

To address this problem, Federal policymakers should increase options for primary care practices to benefit from APMs that provide up-front or advance payments and other supports to enable the investments required to be successful. For example, practices participating in CPC+ not only received population-based, per-member per-month (PMPM) payments, but CMMI provided them with a robust data dashboard and other technical assistance that enabled new practices to join the

model and successfully reduce emergency visits and hospitalizations. CMMI also partnered with State Medicaid agencies and commercial payers to drive alignment across payers in CPC+ regions, which in turn provided practices with greater financial support across their contracts and accelerated care delivery innovations.

We are encouraged by CMS's recent announcement of a new model, ACO Primary Care Flex, which will heed our recommendations and provide low revenue ACOs participating in the Medicare Shared Savings Program (MSSP) with a one-time up-front shared savings payment and a prospective PMPM payment. CMMI's forthcoming Making Care Primary (MCP) model, which is set to launch in July, also builds upon lessons learned from CPC+ and Primary Care First (PCF) and provides participants who are new to value-based care with up-front payments to develop infrastructure and build advanced care delivery capabilities. CMMI is also working with State Medicaid agencies and other payers in the selected States to align MCP and State programs, helping facilitate the multi-payer alignment that has contributed to successful aspects of earlier models.

Congress should also consider providing CMMI with additional flexibility in how it evaluates the success of primary care models. Currently, Federal statute only allows CMMI to expand models that reduce health-care spending and maintain quality, or improve performance on quality metrics without increasing spending. Demonstrating savings in primary care often takes several years as physicians build relationships with their patients, use data to better manage their care, and increase utilization of preventive and other high-value services, like care management.

The current statutory framework has prevented CMMI from making important model improvements or continuing to test models that do not show significant savings within a short model test period, ultimately causing more complexity and financial instability for participating physician practices. Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional successes. Congress should consider enabling and encouraging CMMI to evaluate several other markers of success for primary care APMs, such as whether they successfully bring new physicians into value-based payment, improve patient experience measures, markedly improve care delivery transformation, enable more beneficiaries to access the behavioral health services they need, and when applicable, evaluate models both nationally and regionally. These additional criteria would allow CMMI to continue testing models that show early markers of success and iterate upon them to meet current patient, clinician, and market needs.

While value-based payment can and should be used to buoy primary care practices, health systems, hospitals, payers, and other large companies will continue to enter these models. Federal policymakers should take steps to ensure value-based payment is being used as a tool to significantly increase our Nation's investment in primary care, not as a leverage point to increase profits in other business areas. In other words, payments and financial rewards from APMs should be reinvested into the primary care practice, not redirected to other service lines or books of business.

In closing, thank you again for the opportunity to provide this testimony. On behalf of the AAFP and as a family physician, I look forward to working with the committee to advance policies that invest in high-quality primary care, improve patients' outcomes and experiences, and better support family physicians by more appropriately paying for the work we do. We all have the same goal: to improve the lives of the people we serve.

Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits—that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

QUESTIONS SUBMITTED FOR THE RECORD TO STEVEN P. FURR, M.D., FAAFP

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. As you noted in your testimony and responses during the hearing, numerous features of the Physician Fee Schedule (PFS), as currently structured, have resulted in volatility and uncertainty for clinicians. Broad utilization overestimates for certain new billing codes, for instance, have triggered draconian conversion factor (CF) reductions across all specialties and subspecialties, and policy changes aimed at ensuring appropriate reimbursement for certain subgroups of clinicians necessitate, under budget neutrality rules, sizable payment cuts for others, with no countervailing enhancements for the latter groups.

What specific legislative steps should Congress consider taking in order to provide long-term stability and sustainability for the PFS, beyond modifying the current CF update schedule?

Answer. In addition to updating the conversion factor by applying an annual inflationary update based upon the Medicare Economic Index, the AAFP strongly urges Congress to make immediate reforms to existing budget-neutrality requirements. As noted in my written testimony, the zero-sum, budget-neutral nature of the MPFS is undermining investments Medicare tries to make in primary care. Existing budget-neutrality requirements force CMS to offset increases or additions anywhere in the MPFS with across-the-board cuts to all services in the MPFS, including those most delivered by primary care physicians. In short, this means Medicare cannot appropriately pay for all the services a patient might need, and it perpetuates inequities in the fee schedule, which bleed into and impact the success of primary care practices in VBP arrangements and outside of Medicare.

Budget neutrality is unnecessarily pitting physician specialties against one another. We strongly urge the committee to consider proposals such as increasing the current budget neutrality threshold, which has not been updated since the fee schedule was created in 1992, correcting the impact of over or underutilization assumptions by CMS on the availability of funds, and more regularly updating the direct costs used to calculate practice expense Relative Value Units (RVUs).

I'd also like to raise the suggestion that Federal policymakers should think of and interpret budget neutrality in broader terms than it currently is. As I've discussed, proper investment in primary care yields the potential to increase long-term cost savings through outcomes such as reduced emergency department visits, hospitalizations, and better management of chronic conditions. I would make the case that those savings should be considered as part of the direct budgetary impacts of increasing primary care investments in Medicare.

Question. In the absence of these types of steps, what concrete impacts will current and future beneficiaries most likely experience?

Answer. While I cannot predict the future, I can point to the past. Over the last decade or so, we have seen more and more primary care practices closing their doors or being bought up by a health system, hospital, insurer, or private equity. This trend accelerated during COVID, when primary care practices that were already operating on razor-thin margins were hit with an unprecedented financial reckoning. While we're on the other side of the pandemic now, insufficient Medicare physician payment rates continue to exacerbate the difficult financial environment for many practices. Costs for administrative and clinical staff, medical supplies, and overhead all continue to rise while payment rates go down through a combination of statutorily required cuts and failure to keep pace with inflation. Absent any meaningful reforms from Congress, more primary care physicians will leave the field, practices will close, and most importantly, patients will struggle to access all of the care that they need—particularly preventive and primary care that keeps them from having to pursue more expensive care in costlier settings.

Question. Regulations finalized earlier this year aim to streamline and standardize prior authorization standards and requirements in certain contexts, but the final rule expressly excludes outpatient medications, whether administered by clinicians or dispensed to beneficiaries via pharmacy. Both the American College of Surgeons (ACS) and the American Academy of Family Physicians (AAFP) made note of this omission in comments submitted in response to the proposed rule.

Specifically, ACS "urge[d] CMS to apply its proposed policies to all drugs covered by any of the impacted payers to align PA processes and related implementation efforts with those for all other covered items and services." Similarly, AAFP expressed

concern and disappointment that “these proposals do not apply to prior authorizations for prescription and outpatient drugs,” and went on to “strongly *urge* CMS to expand the proposals in this rule to Medicare Part D plans and prescription drug coverage across other impacted payers.”

Virtually all clinician organizations concurred with these recommendations, including those focused on treating some of the most onerous chronic conditions, such as cancer. The Community Oncology Alliance, for instance, asserted, “Addressing the drug treatment for a person’s cancer should clearly be part of any effective, comprehensive regulatory initiative to streamline the current onerous prior authorization processes.” Patient advocates uniformly agreed with these concerns, which a number of groups have cited as a key source of delays and denials of potentially life-saving therapeutics, across both the provider-administered setting and the retail pharmacy context.

Studies have found that physician-administered drugs and biologics account for a large and growing share of all forms of prior authorization and utilization management (UM) under Medicare Advantage (MA) plans’ medical benefits, and the application of various UM tools, such as prior authorization, step therapy, and formulary exclusion, has risen dramatically in recent years under Medicare Part D plans. Analysts broadly project that these trends will accelerate, rather than reverse, in the midst of Part D’s benefit redesign.

What specific components should Congress, or CMS, consider including in any effort to streamline and otherwise reform requirements and standards for UM tool application to outpatient drugs (both physician-administered and pharmacy-dispensed)?

Answer. In a 2023 rule, CMS proposed requirements to adopt the updated National Council for Prescription Drug Programs (NCPDP) SCRIPT (standards used to exchange information for e-prescriptions) version 2023011 (and to retire version 2017071) for Part D e-prescribing starting January 1, 2027. CMS also proposed to update other e-prescribing related standards including the adoption of NCPDP Real-Time Prescription Benefit (RTPB) standard version 13 for real-time benefit transactions (RTBT) and the adoption of NCPDP Formulary and Benefit (F&B) standard version 60. The AAFP supported these proposals.¹ CMS did not announce a final decision in the published rule and we assume these proposals are still under consideration.

The AAFP also supported earlier proposals to adopt NCPDP RTPB standards, which enable the real-time exchange of patient-specific coverage (including restrictions and alternatives) and estimate cost-sharing at the point of prescribing.² We supported CMS’s proposal, which they finalized in the 2024 Part D rule, to adopt RTPB standard version 13 because it would offer enhancements that would enable payers to provide additional product-level details about coverage and formulary status.

NCPDP F&B standards enable plans to share formulary and benefit information at the plan level, as opposed to the patient-level eligibility information offered by RTPB standards. These standards allow payers to transmit information about formulary status, preferred alternatives, and coverage restrictions consistent with each plan’s benefit design. F&B standards are the foundation of electronic prior authorization (ePA) functionality and real-time benefit checks for individual patients in Part D. We have previously urged CMS to require plans (including Part D plans) to implement ePA standards, and we support the adoption of the proposed F&B standards which will facilitate the use of ePA in Part D plans.³ Currently, family physicians spend a significant amount of time determining whether a prior authorization is required, and if so, the documentation requirements for approval. We believe this proposal is a foundational step to require Part D plans to implement ePA and make prior authorization requirements more transparent to physicians and their staffs. CMS did not announce a final decision in the published rule and we assume these proposals are still under consideration.

CMS requires Medicare Advantage plans to use coverage criteria that is no more restrictive than Traditional Medicare coverage policies. When there are no applica-

¹<https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/LT-CMS-MedicareAdvantageCY25-122123.pdf>.

²<https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/medicare/LT-HHS-CMS-MedicareAdvantagePriorAuthorization-021323.pdf>.

³<https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/LT-CMS-PriorAuthorizationEHR-031023.pdf>.

ble Medicare statute, regulation, National Coverage Determination (NCD) or Local Coverage Determination (LCD) that establish coverage criteria, plans may only create internal coverage criteria based on publicly available clinical literature or widely used treatment guidelines. We urge CMS to apply this proposal to prescription drugs and Part D plan sponsors.

Question. What benefits would these components offer to patients and clinicians?

Answer. The NCPDP RTPB standards discussed above would allow family physicians to understand formulary and prior authorization requirements for patients when writing a prescription, which aligns with AAFP policy stating physicians must have real-time information available about drug formularies at the point of care.⁴ These more recent standards would increase transparency of prior authorization requirements, formulary design, and patient financial responsibility at the point of prescribing. Having this data at the point of prescribing would allow physicians to have a more robust discussion with patients about treatment options. We continue to support the use of ePA standards in Medicare Part D plans and urge Congress and CMS to apply these standards to all other non-Part D prescription plans.

Question. In the absence of reform efforts along these lines for medications, what prior authorization and UM burdens and other effects will clinicians and beneficiaries continue to experience, even after CMS's final rule takes effect?

Answer. I experience—and frequently hear from other family physicians who do as well—significant administrative burden associated with PA requirements for prescription drugs. PA processes force physicians to take time away from patient care to understand arbitrary formulary changes and/or new PA requirements. Without access to plan coverage details at the point of prescribing, physicians spend a significant amount of time going back and forth with the pharmacy to identify alternative medicines that meet coverage requirements. In addition to the burden on physicians, these PA processes increase burden on pharmacists and beneficiaries.

Question. On a number of fronts, CMS has leveraged subregulatory guidance as a means of clarifying current-law and regulatory requirements for plans, providers, and beneficiaries. In the context of Part D, 42 CFR 423.272(b)(2) establishes regulatory requirements for plan designs, noting that the agency will not approve a bid if “the design of the plan and its benefits (including any formulary and tiered formulary structure) or its utilization management program are likely to substantially discourage enrollment by certain Part D eligible individuals under the plan.” Notably, clause (iii) specifies that even if a plan adheres to proper category/class inclusion requirements, such a plan may still fall short of this standard by virtue of its exclusion of certain drugs.

Patients, providers, and plans, however, have flagged uncertainty as to the scope and practical implications of this language. Updates to the regulations themselves, or else to the relevant sections of the Medicare Prescription Drug Manual, could present a potential avenue for clarifications, along with exemplary examples of compliant and noncompliant formulary design and UM tool applications.

What types of clarifications or examples, in this context, could CMS provide, either through guidance or regulations, to ensure adequate and efficient medication access for Part D enrollees, many of whom take multiple prescriptions for chronic diseases?

Answer. Part D, 42 CFR 423.272(b)(2) establishes regulatory requirements for plan design including a prohibition on excluding certain drugs that, if not included, might discourage sicker patients from enrolling. Chapter 6 of the Medicare Prescription Drug Benefit Manual,⁵ Part 30.2.5—Protected Classes requires plans to include “substantially all” drugs in certain classes, and CMS notes this policy was established to “ensure that Medicare beneficiaries reliant upon these drugs would not be substantially discouraged from enrolling in certain Part D plans, as well as to mitigate the risks and complications associated with an interruption of therapy for these vulnerable populations.” Guidance in the same section further states, “Part D sponsors may not implement PA or ST requirements that are intended to steer beneficiaries to preferred alternatives within these classes for enrollees who are currently taking a drug.” The policy includes “all drugs in the immunosuppressant (for

⁴ <https://www.aafp.org/about/policies/all/patient-centered-formularies.html>.

⁵ <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf>.

prophylaxis of organ transplant rejection), antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes.)

We encourage CMS to consider whether this policy or list of conditions should be expanded. There may be more categories of conditions or drugs that support their intent of reducing harms and complications associated with an interruption of therapy. For example, the CMS Innovation Center is developing a model that establishes a list of 150 commonly filled generics and sets their copay at two dollars.⁶ Many chronic diseases can be managed with low-cost prescription drugs, and establishing a formulary standard for commonly prescribed, low-cost generics used to treat chronic disease would help patients with multiple chronic diseases by reducing their total copays, and by preventing patients from being forced to change prescriptions due formulary changes, despite the fact that their disease is currently well controlled.

Question. In some cases, formularies exclude or disadvantage lower-cost alternatives to branded medications with higher list prices while charging beneficiaries coinsurance tied to said inflated sticker-price figures. The Part D statute directs pharmacy and therapeutic (P&T) committees to “base clinical decisions on the strength of scientific evidence and standards of practice,” but it remains unclear to what extent these committees or the Part D plans themselves factor cost sharing, UM hurdles, or lower-priced alternatives (and the role of rebates) in making these types of determinations.

How does cost-sharing burden affect medication adherence and clinical outcomes for patients, and how should plans (and their P&T committees) incorporate these types of considerations into their recommendation and review processes?

Answer. Cost sharing has very tangible, and often negative, impacts on patients’ medication adherence and clinical outcomes. In my practice, I have experienced patients requesting a certain medication for the sole reason that it had a lower cost-sharing amount, regardless of whether it was the best treatment or what I would recommend. I have had patients stop taking medication or ration doses because of the costs. Research has backed up my anecdotal experiences, as well. Studies have consistently shown that, regardless of disease area, increased cost sharing was associated with worse adherence, persistence, or discontinuation, with data suggesting that the more significant the cost sharing, the worse the treatment or medication adherence.⁷ For example, one study found that a low copayment for generic statins is the strongest factor influencing their utilization and eliminating the copay altogether has an even larger effect.⁸

The AAFP’s policy on patient-centered formularies provides several recommendations to inform these recommendation and review processes, including:⁹

- Formulary design should be patient-centered, fiscally responsible, and evidence-based. Drug selection should be based on clinical outcomes, clinical comparability, safety, patient ease of use, and bioequivalency with drug unit cost being a secondary consideration.
- Formularies should be designed to offer patients multiple levels of drug choice (from more to less restrictive) with accompanying patient cost-sharing levels to account for variables including patient preferences (e.g., “direct marketing-induced” demand).
- Formularies should be designed to reduce or eliminate out-of-pocket costs for patients with chronic conditions to increase medication adherence and improve patient well-being.
- Health plans and PBMs should provide drug utilization and cost information to physicians in clear and understandable reports that are useful for physicians in affecting positive change in their prescribing behavior.
- Sufficient information concerning PBM design should be provided by health plans to physicians and patients in a clear and useful format. (Note: this includes information concerning generic drug and therapeutic substitution policies, deductibles and copays, appeal process for adverse decisions, formulary

⁶<https://www.cms.gov/blog/cms-innovation-centers-one-year-update-executive-order-lower-prescription-drug-costs-americans>.

⁷<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10394195/#:~:text=The%20majority%20of%20publications%20found,sharing%2C%20the%20worse%20the%20adherence>.

⁸https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0019?url_ver=Z39.88-2003&rft_id=ori%3Arid%3Acrpubref.org&rft_dat=crpub++0pubmed.

⁹<https://www.aafp.org/about/policies/all/patient-centered-formularies.html>.

choices, product information, contractual arrangements with a PBM, et cetera).

Question. What formulary review mechanisms or reporting requirements could CMS implement in order to ensure effective and meaningful oversight of formulary design, UM tool application, and the clinical basis for these decisions?

Answer. A 2019 analysis found that 72 percent of the formularies reviewed placed at least one branded drug in a more favorable (lower-cost) tier than its generic, and the price of the branded drug was nearly four times the cost of the generic.¹⁰ We believe CMS should consider the impact of this type of cost sharing when evaluating the adequacy of a formulary. A 2023 GAO report, “CMS Should Monitor Effects of Rebates on Plan Formularies and Beneficiary Spending”¹¹ noted similar findings: “rebate practices may influence formulary design in ways that could affect beneficiary access for certain Part D drugs and may not be identified by a clinical formulary review.” Reviewing plan rebate structures during the clinical plan design and benefits review could enable CMS staff to assess whether a drug may be at risk for lower adherence rates due to patient cost sharing, and help to identify when copays might discourage certain beneficiaries from enrollment.

Question. Artificial intelligence (AI) has the potential to mitigate administrative burden and enhance health-care quality, including in the context of Medicare. That said, some clinicians have raised concerns around the program’s inability to keep pace with AI-enabled tool development through its coverage and payment policies, undercutting access, especially for smaller practices.

What use cases for AI-enabled tools and technologies seem most promising in the context of clinician care?

Answer. AI-enabled tools that focus on administrative burden reduction have the most promise today for supporting clinicians. Five key areas of administrative burden are documentation, prior authorization, EHR inbox management, quality measurements, and chart review. We have seen how AI assistants can dramatically reduce documentation time and cognitive burden of chart review, while supporting more timely and empathetic responses to inbox messages. We have also seen how AI assistants can reduce the burden of coding for billing and risk-based adjustments under value-based care. The AAFP is hopeful for additional AI-powered solutions to help with prior authorization and quality measurement.

In the near future, there is promise for AI to power technologies that help primary care be more comprehensive, provide better continuity and coordination of care, and improve patient access. Work is still needed to address the issues of trustworthiness and safety as AI moves more into the clinical realm.

Question. What steps should CMS and Congress take to ensure adequate coverage and reimbursement for appropriate AI-enabled tools in this context?

Response: For the administrative burden reduction use cases, coverage and reimbursement are not the key barriers; rather, issues of interoperability with EHRs and willingness for health-care systems to invest are key to further adoption. There is clear evidence that investments in primary care result in lower total costs and improved patient outcomes. So, as the investment in primary care more generally happens to align payments with the value generated, this could also incentivize health-care systems to invest in primary care infrastructure, including AI solutions.

On the near future clinical applications, it is important for coverage to allow for primary care physicians to practice to the top of their training and not have coverage tied to a particular specialty. This is due to the opportunity AI has to empower primary care physicians to be more comprehensive.

The biggest potential driver of responsible AI-powered solutions for clinical care is the alignment of payment to high-quality primary care and to pay prospectively. This alignment incentivizes the adoption and use of AI that improves outcomes and lowers total cost. Furthermore, additional fee-for-service payments can be used to accelerate adoption of newer solutions.

¹⁰<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2728446>.

¹¹<https://www.gao.gov/assets/gao-23-105270.pdf>.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. In 2005, this committee held a hearing that I chaired titled, “Improving Quality in Medicare: The Role of Value-Based Purchasing.” I said at the time that we do not want to overburden providers with reporting requirements. I went on to say that it is important to develop these health care quality measures by consensus.

Do you feel reporting requirements are developed by consensus and do not overburden providers? If not, what actions should we take to reduce the burden?

Answer. We support the goal to implement health care quality/performance measures that do not overburden physicians. We appreciate HHS’s and CMS’s efforts to improve the measurement landscape by recommending a “Universal Foundation,”¹² which is one step toward measure alignment across programs. We also appreciate the ability to participate in annual, multistakeholder, measure review processes to make recommendations for measures that should be implemented in Federal programs like Medicare, as well as measures that should be removed from use in Federal program. That said, there’s still a tremendous amount of work that must be done to decrease the significant burden created by the current measurement landscape. While quality measurement is essential to moving toward a value-based health-care system, our current approach fails to measure what matters to patients and clinicians or drive meaningful improvement. The eagerness to measure has burdened family physicians with the onerous task of capturing structured electronic data to feed an excessive number of measures, taken time away from patients, and led to loss of joy in practice.

To further reduce burden, we recommend the following actions:

- Use fewer measures overall and implement only those measures focused on improving outcomes that matter to patients and/or improve health equity.
- Align performance measures and other aspects of value-based payment models across *all* payers and programs.
- Continue to involve physicians and patients in selection of measures to be used in Federal programs and allow their feedback to help determine which measures are used.
- Ensure physicians are measured according to patients who truly are under their care, and provide physicians and clinics with rosters of patients for whom they are accountable on a timely basis and in an easy-to-use format.
- Optimize health information exchanges and allow primary care physicians easy access to real-time health information showing care provided to their patients outside their clinic.
- Ensure all electronic health record (EHR) systems are equipped to discretely capture and electronically report performance measures before implementation without any added administrative burden or cost.
- Ensure Federal payment programs provide coverage for care where physicians are held accountable via performance measures (*e.g.*, physicians should be able to administer the shingles vaccine in their offices if they are being measured on it).

Question. According to the Medicare Payment Advisory Commission (MedPAC), Medicare’s Physician Fee Schedule updates have grown more slowly than input cost growth in recent years. Yet Medicare spending on an annual basis is up 30 percent over 5 years and the Congressional Budget Office (CBO) just revised Medicare spending for benefits—for this year and last year—up another \$272 billion. MedPAC explains this is due to an increase in the volume and intensity of Medicare services.

Can you explain the root cause for higher Medicare spending while at the same time, physicians are receiving less in reimbursement?

Answer. By law and with some exceptions, Medicare generally covers only the diagnosis and treatment of illness or injury rather than prevention. Thus, part of the root cause for higher Medicare spending is the program’s inclination to pay for a pound of cure rather than an ounce of prevention.

Beyond that, Medicare spends less than 5 percent of its total spending on primary care. Between 2019 and 2021, there was a 15 percent drop in Medicare spending on primary care.¹³ When we look at health outcomes across the world, we’re not

¹² <https://www.cms.gov/medicare/quality/cms-national-quality-strategy/aligning-quality-measures-across-cms-universal-foundation>.

¹³ <https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/>.

doing well by almost any measure. Compared to other high-income peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.¹⁴ We know from extensive evidence that other countries and even U.S. States that invest a greater percentage of spending in primary care reap the benefits in reduced overall spending. Thus, the biggest root cause for higher Medicare spending is the program's failure to invest in primary care and over-investment in other facets of the health-care system.

Question. There are an estimated 8,000 medical services codes that physicians bill for a range of health-care services.

How many are typically used in a primary care setting? Are the suite of primary care codes overly burdensome or complicated? If so, how? How does this compare to billing under Medicare Advantage or other commercial insurance?

Answer. The number of codes by themselves is not overly burdensome or complicated. What is burdensome and complicated are the myriad rules (some associated with the code set(s) and others created by Medicare and other payers) that govern when codes may be reported either independently or in conjunction with other codes. This is true in almost any fee-for-service payment system, whether traditional Medicare, Medicare Advantage, or commercial insurance. Research has concluded that creating additional billing codes for distinct activities in the MPFS may not be an effective strategy for supporting primary care,¹⁵ due to the burden associated with billing each one. This is part of the reason the AAFP advocates for prospective, risk-adjusted per-patient per-month payments for the continuous, comprehensive care delivered by primary care physicians.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. Health plans are legally required to offer to pay medical practices through standardized electronic payments, similar to the direct deposit system through which many Americans receive their paychecks. These payments are known as electronic fund transfers, or EFTs. Receiving payments electronically is convenient, but there's a catch. Health plans use vendors to process EFTs that charge physicians processing fees of 2 percent to 5 percent of the claims payment. Under this egregious system, physicians are essentially "paying to get paid" and receiving less than the fully contracted payment amount for care that they already provided.

In a survey conducted by the Medical Group Management Association, nearly 60 percent of physician practice respondents said they are forced to pay these percentage-based fees without ever having agreed to them. These fees are particularly burdensome for small practices, which may not have the margins or administrative support to cope with them.

To address this problem, Senator Cassidy and I introduced the No Fees for EFTs Act earlier this year. Our bill would prohibit health plans from imposing these unnecessary fees for electronic transfers on providers. Doctors should be focused on providing care, not dealing with burdensome EFTs.

Are your members or you personally subjected to these fees? Could you comment on how they affect the financial outlook for practices who treat a high portion of patients with complex chronic care needs?

Answer. Yes, I hear from family physicians who are subjected to these fees. The AAFP has previously expressed concerns to CMS about physicians incurring fees for electronic payments from health plans.¹⁶ Family medicine practices report that they are increasingly forced to pay mandatory, percentage-based fees for the receipt of electronic payments made from health plans via the electronic funds transfer (EFT) transaction standard. These fees are adding to practices' already overwhelming administrative burden and ongoing financial strain. Practices cannot afford to lose a percentage of each claim payment due to EFT fees. Disenrolling in EFT payments is often not permitted by payers, but when allowed it leads to additional administrative tasks that take time away from patient care.

¹⁴<https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going>.

¹⁵<https://www.acpjournals.org/doi/10.7326/M21-4770>.

¹⁶<https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/LT-CMS-EFTFees-102221.pdf>.

Question. Do you agree that the No Fees for EFTs Act would help protect providers from unfair processing fees?

Answer. Yes. The AAFP is proud to have endorsed your legislation,¹⁷ the No Fees for EFTs Act, to help protect family physicians and other clinicians from these fees, as you note.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. In 2015, Medicare began reimbursing providers for chronic care management under a separate code in the Medicare Physician Fee Schedule. This code was supposed to compensate providers for the additional time needed outside of a typical visit to coordinate care for patients with chronic diseases, but only a fraction of eligible Medicare beneficiaries have received these services.

Under current CMS guidelines, eligible chronic care management beneficiaries must have two or more chronic conditions. This can include mental health conditions like depression or a substance use disorder.

What is preventing better utilization of these services?

Answer. Although CCM helps prevent hospitalizations and emergency department visits, it is subject to beneficiary cost sharing, unlike most preventive services. For monthly services, such as CCM, this means patients must pay cost sharing each month. This cost sharing prevents better utilization, especially among beneficiaries who are financially disadvantaged and those without a supplemental policy (e.g., Medigap).

Another barrier to better utilization is the way CCM codes are structured and paid under fee-for-service. The code descriptors and payers require a certain number of minutes of clinical staff or physician (or qualified health professional) time to be documented before the codes may be submitted and claimed. This necessitates tracking individual interactions with the patient or on the patient's behalf over the course of a calendar month before a claim can be submitted. Tracking and documenting that information over the course of a month to claim payment in a fee-for-service environment is cumbersome and sometimes deters use of services, especially as compared to a payment model where such services are paid on a prospective, per-patient per month basis for attributed beneficiaries.

Question. For the estimated 1.7 million Medicare beneficiaries with a substance use disorder, can using this code improve outcomes for this more vulnerable patient population? For example, how might this reduce patient emergency room visits?

Answer. I don't know of any research that specifically looks at use of the CCM code for Medicare beneficiaries with SUD, but some research has indicated that CCM more broadly has the potential to be a successful model for treating patients with SUD.¹⁸ However, I do believe that one of the remaining and significant barriers that may prevent the full benefits of CCM being realized for this population is the insufficient number of behavioral health clinicians, particularly those that are trained in CCM.

Question. Do CCM services reduce overall health-care costs for chronic care patients when used?

Answer. Data has indicated that the answer to your question is yes. CMMI released a report showing that CCM was associated with lower growth in Medicare costs,¹⁹ reduced hospital admissions and increased connections with community-based resources for patients. Over an 18-month period, it reduced costs by \$74 per beneficiary per month. CMS claims data has shown that if a patient is in the program for at least a year,²⁰ Medicare achieves \$888 per patient, per year in gross savings. Additionally, patients in CCM had lower hospital, ED, and nursing home costs and CCM was linked with a reduced likelihood of hospital admission for people

¹⁷ <https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/LT-Senate-NoFeesEFTsAct-032524.pdf>.

¹⁸ [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3902022/#:~:text=CCM%20is%20multidisciplinary%20patient%2Dcentered,\(a%20substance%20use%20disorder\).](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3902022/#:~:text=CCM%20is%20multidisciplinary%20patient%2Dcentered,(a%20substance%20use%20disorder).)

¹⁹ <https://www.cms.gov/priorities/innovation/files/reports/chronic-care-mngmt-finalvalrpt.pdf>.

²⁰ <https://www.chartspace.com/blog/effectivity-of-chronic-care-management-programs/>.

with diabetes, chronic obstructive pulmonary disease, congestive heart failure, urinary tract infection, dehydration, and pneumonia.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. As part of the Merit-based Incentive Payment System (MIPS), physicians must be compliant in promoting interoperability as part of their reimbursement, which helps to facilitate the sharing of data between various providers.

I have long been an advocate for health IT initiatives that can improve efficiencies and reduce costs in the health-care system, and I believe that sharing information between providers through an interoperable network has immense upside, so long as there are safeguards to protect patient privacy and ensure taxpayer funds are spent appropriately.

However, there continue to be challenges to physicians meeting interoperability metrics, like information blocking for example in which an individual or entity impedes the delivery or utilization of an electronic health record, making interoperability impossible.

In your view, how have practices been impacted by information blocking?

Answer. Practices have been impacted both by information blocking itself, as well as by information blocking regulations. The AAFP has long supported efforts to advance the interoperability of health IT, including through the Office of the National Coordinator (ONC) for Health IT's development of information blocking regulations. Despite ONC's longstanding efforts to reach and educate the health-care community about information blocking, significant knowledge gaps still exist regarding the implementation and enforcement of information blocking regulations. Several independent, small, rural, and solo medical practices are still unaware or underinformed about information blocking requirements. The AAFP has urged HHS,²¹ ONC, CMS, and other agencies to develop an intraagency communications plan and educational outreach program specifically designed to reach physicians in underserved communities and small practices. Family physicians want to follow regulations and appropriately share information with their patients and other members of their patients' care team, and significantly more education is needed for practices to be able to achieve those goals.

Question. Are you aware of instances in which the timeliness or quality of the care physicians are able to provide patients has been impacted by a limited ability or complete inability to access electronic health records?

Answer. Yes. My family physician peers have shared several examples.

- A clinical example is medication reconciliation. One family physician shared that they use a different EHR than their local hospital system, and the ER and inpatient services cannot see the physician practice's updated medication list despite both organizations being connected through Epic's Care Everywhere. When patients are discharged from the hospital, they are routinely discharged on a medication list that has no reflection of their home medications because the medication list in the hospital system was wrong in the ER, stayed wrong upon admission, was never corrected during the hospitalization, and was of course all wrong upon discharge.
- Another physician stated that consulting subspecialists in their two main systems assume that "everyone" can see their notes and no longer send chart notes in response to referrals. The practice's referral coordinator spends time every day trying to track down consult notes from subspecialists who think their notes are visible throughout the system due to their "connected" systems. When notes do come in as an electronic "Record of Care," they are not tied back to the referral order to close the loop automatically. Instead, they must be manually labeled as a consult note and attached to the order that generated the initial referral by a staff person or the physician.
- A physician stated that they are unable to get the data from outside laboratories to know if the patient got the test. They must resort to having the patient follow up with another appointment to ensure the labs were completed and where, so they can request the results.

²¹ https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/ehr/LT-HHS-ONC-InformationBlocking-122223.pdf.

- Finally, a physician stated that they are unable to get data from an urgent care center and are forced to call the center and request the information be faxed to them. These are not isolated events, but rather we hear these types of stories all the time. The lack of interoperability increases costs, delays care, and adds burden to primary care to find and get the needed data.

Question. Furthermore, beyond information blocking, what other challenges persist in physicians accessing patients' health information electronically despite the billions of dollars spent to implement electronic health IT and interoperability?

Answer. See above for examples that also respond to this question.

QUESTION SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. Your testimonies and discussions at the hearing noted that the Merit-based Incentive Payment System (MIPS) is cumbersome for clinicians. The intention of MIPS is to foster performance improvements, leading to better outcomes for patients. You all mentioned that MIPS is burdensome and may not accurately capture the quality of care physicians provide.

Are there policy proposals that could be implemented to make MIPS more accurate and less burdensome?

Answer. MIPS uses four siloed performance categories—all with different measures and reporting requirements. Despite multiple calls for consolidation and cross-category credit, CMS argues that they do not have the statutory authority to alter the program in that regard. One significant step toward reducing burden would be to give CMS the flexibility to provide cross-category credit. For example, a physician who reports a quality measure related to depression screening should automatically receive credit for the corresponding improvement activity.

The AAFP has also repeatedly advocated that CMS allow practices to attest to using CEHRT rather than requiring multiple burdensome measures for the promoting interoperability category. Again, CMS does not have the authority to offer such an option. As we noted in our comments on the 2024 MPFS NPRM, years of policy changes to the legacy Meaningful Use program and now the promoting interoperability category have failed to move the needle on health information exchange. It is beyond time to move away from such burdensome requirements—doing so would be an important step toward reducing the burden of the MIPS program.

QUESTION SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. I am working on a bill to relieve providers excelling in the Medicare Shared Savings Program (MSSP), from prior authorization (PA) requirements in MA. The bill rewards providers in Accountable Care Organizations (ACOs) that generate savings for Medicare by granting an exemption from PA requirements for their MA beneficiaries. If an insurer believes there is a rationale for maintaining PA in such instances, this bill would require them to seek prior approval from the Centers for Medicare and Medicaid Services (CMS). I would welcome your thoughts and comments on this idea.

Answer. AAFP policy supports the concept that family physicians that contract with health plans to participate in a financial risk-sharing agreement should be exempt from prior authorizations.²²

QUESTION SUBMITTED BY HON. MAGGIE HASSAN

Question. I am working with my colleagues on the Finance Committee to address discrepancies in Medicare reimbursement that disadvantage independent doctors. Older adults, and the Medicare program, often pay a huge markup for basic services if their provider's office is owned by a hospital.

If a patient on Medicare with arthritis received a routine steroid injection from an independent doctor, Medicare would pay \$50 and the patient would pay about \$15. For the same injection at an office owned by a hospital, Medicare would pay \$250, and the patient would pay \$60.

²² <https://www.aafp.org/about/policies/all/prior-authorizations.html>.

What impact does this huge price differential have for patients in rural areas, and how can we level the playing field so that we are not disadvantaging physician-led care?

Answer. The AAFP has been strongly calling for Congress to advance policies that will meaningfully address site-of-service payment differentials for the reasons you identified in your question:²³ they are creating an uneven playing field for independent practices across the country and patients are quite literally paying the price for it, without getting anything in return.

There is little evidence that these additional payments hospitals are able to charge are reinvested in the acquired physician practice, many of which are primary care practices. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.

Medicare's increased payments for services performed in HOPDs does not just impact the Medicare program and beneficiaries, however. Private health plans generally use Medicare's payment system as a basis for how much they pay physicians and hospitals, meaning that this influences and directs spending and resources among commercial plans and patients. Therefore, adopting comprehensive site-neutral payment policies in Medicare would have significant impacts in saving money across the health-care sector, with one study estimating that it would lead to \$471 billion in savings over the next 10 years.²⁴

In terms of direct patient costs, Medicare patients collectively would save about \$67 billion on Part B premiums and \$67 billion on cost sharing. Premiums for private health insurance plans would be about \$107 billion lower over that period, which would amount to a reduction in aggregate premiums of 0.75 percent. Privately insured patients would also save about \$18 billion on cost sharing due to lower payment rates.

Therefore, the AAFP continues to encourage Congress to extend payment parity for all clinically appropriate services to off-campus HOPDs established before 2015. We have also supported more incremental policies such as requiring that payment for physician drug administration services be the same in an off-campus HOPD as in a physician's office.

QUESTIONS SUBMITTED BY HON. MARSHA BLACKBURN

Question. Medicare physician pay and its impact on patient access to care remains a significant issue for my constituents. Adjusted for inflation in practice costs, Medicare physician pay plummeted 29 percent from 2001 to 2024. Although Congress did act in the March 8th government funding package to reduce the 3.37-percent cut that went into effect on January 1, 2024, by an additional 1.68 percent, the 29-percent reduction in Medicare payments over the last 2 decades is reflective of this most recent congressional action. Plus, physicians are now set up for another steep payment cut at the end of this year. Nonpartisan government stakeholders recognize the damaging impact these cumulative payment cuts have on patient access to care. Multiple Medicare trustee reports stated that "absent a change in the delivery system or level of update by subsequent legislation, the trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

Can you discuss some of the impacts of this pressing financial instability on physician practices, including consolidation, difficulty retaining staff, and trouble keeping their doors open amid rising costs?

Answer. Your question includes much of the answer. Insufficient payment rates, particularly for small, independent primary care practices that are already operating on thin margins, make it extremely difficult for them to compete with hospitals, health systems, plans, and other corporate entities who are recruiting for the same staff with more attractive salaries and more significant resources (such as access to advanced tools and technology, additional administrative support, and other experts). For the physician, increasingly high rates of student loan debt have a clear impact on the decision for many to choose employment with a well-resourced system or plan. All of these factors together, in addition to having to comply with an ex-

²³ <https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/LT-HouseEC-HealthCareSpending-013124.pdf>.

²⁴ https://www.bcbs.com/sites/default/files/file-attachments/affordability/Phil_Ellis_Site_Neutral_Payment_Cost_Savings_Report_BCBSA_Feb_2023.pdf.

tremely burdensome regulatory environment, are accelerating consolidation within primary care.

Question. What available mechanisms do Congress and HHS have within current statutory authority to help provide adequate Medicare payments to physicians and ensure continued patient access to care? For example, alleviating the administrative burden on practices through reforms to the Merit-based Incentive Payment System?

Answer. As noted in a response above, we have made several recommendations on ways to improve MIPS and alleviate associated administrative burden on practices—however, CMS has indicated their statutory authority to do so is limited. Absent congressional action, CMS and HHS do not have much existing authority that allows them to provide adequate Medicare payments to all physicians. For example, efforts made by CMS to try and better value primary care within their existing authority have required them to also offset these investments by cutting payment for all Medicare fee schedule services (including all of the other primary care services). Congress must lead the charge on providing adequate Medicare payments to physicians by first reforming budget-neutrality requirements and implementing an annual inflationary update for physician payment based upon the MEI, as two important starting points.

Question. Do these cuts disproportionately impact access to care in underserved areas?

Answer. As a rural family physician, I can attest that the answer is “yes.”

Question. As a value-based purchasing program, MIPS was supposed to reward physicians who achieved quality and cost-efficient care. However, for years physicians have raised concerns about the program, including that it increases administrative burden and does not accurately capture quality.

What has been your experience with MIPS and the administrative burden that it entails?

Answer. I have heard from many family physicians that MIPS has not supported them in the transition to alternative payment models but rather it has only contributed to significantly more time spent on administrative tasks. A 2021 study in *JAMA*²⁵ of the time and financial costs to practices to participate in MIPS found that small and medium primary care practices had mean per-physician costs of \$18,466 and \$13,631. It also found that physicians, clinical staff members, and administrators spent 201.7 hours annually per physician to participate in the MIPS program. Physicians alone spent more than 53 hours per year on MIPS activities. These statistics are even more significant when you consider that they only apply to MIPS, and family physicians often participate with 7–10 different payers.

Question. Is it time to consider replacing the program with a more valuable alternative? If so, what are some of the program's benefits that should be considered when designing its replacement?

Answer. Whether it's complete replacement or a significant overhaul, it is clear that the current program is not working as intended.

The MACRA statute included funding for technical assistance. However, this funding expired, and the Small, Underserved, and Rural Support (SURS) program ended in 2022. The SURS Extension Act (H.R. 6576) would have authorized additional funding, but it has yet to move. The SURS program provided valuable and direct assistance to practices through tools and resources to help them navigate the complex MIPS reporting requirements. Under the current structure, the performance threshold will continue to increase. We've already seen that these practices are more likely to face difficulties in meeting the performance threshold, which will lead to significant payment adjustments.

Without continued technical support as well as other program reforms, the disproportionate financial impact may accelerate consolidation and exacerbate access issues. We believe technical support for practices is just as important as program design and critical to ensuring practices can succeed under value-based payment arrangements. We urge Congress to provide additional funding for such support.

While the statute requires the Secretary to provide performance feedback data to physicians, CMS has not been able to develop a mechanism that provides timely and

²⁵ <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947>.

actionable information to physicians. Feedback reports often include data that is 2 years old—making it outdated and significantly limiting its utility.

Question. How have your practices been impacted by information blocking?

Answer. See above responses to the questions posed by Senator Thune.

Question. Have you had experiences where your ability (or inability) to access health records has impacted the timeliness or quality of the care you are able to provide your patients?

Answer. See above responses to the questions posed by Senator Thune.

Question. Do existing Federal quality and payment incentive programs under Medicare, like “Promoting Interoperability” under the Merit-based Incentive Payment System, enable up-to-date, consolidated longitudinal health records accessible without special effort?

Answer. No.

Question. With over \$40 billion spent and nearly 2 decades of effort put into implementing electronic health information technology, fax machines remain widely used for sharing health data in our health-care system.

Why is this the case, and what challenges persist in accessing patients’ health information electronically?

Answer. Fax machines are reliable, easy to use, and HIPAA-compliant. They also have a single, standard way to send information to many entities. For small and underresourced practices in particular, fax machines can be a straightforward way to securely exchange health information. Additionally, lack of technological literacy and lack of access to reliable broadband Internet are two significant obstacles to patients’ health information being electronically accessible.

AAFP members have shared stories of their EHR vendor blocking access to records during billing negotiations or disputes, examples of previous EHR vendors refusing to share records that should have been transferred during EHR transitions, and instances of hospitals refusing to send an admission, discharge, and transfer (ADT) or to provide access to summary of care documents for physicians without staff privileges. These are just a few of many challenges that persist today when attempting to access patients’ health information electronically.

PREPARED STATEMENT OF MELANIE MATTHEWS, MSN, CHIEF EXECUTIVE OFFICER, PHYSICIANS OF SOUTHWEST WASHINGTON; AND PRESIDENT, MULTICARE CONNECTED CARE

Thank you, Chairman Wyden, Ranking Member Crapo, and members of the committee, for the opportunity to testify today about how to improve care for people with chronic conditions. My name is Melanie Mathews, and I serve as the chief executive officer of PSW and president of MultiCare Care Connected. I have over 20 years of health-care experience with a focus on the delivery of value-based care.

Founded by independent physicians, PSW has led health-care innovation with the guiding principle of supporting the physician-patient relationship to improve the quality of care since its inception in 1995. Committed to the value of innovation, PSW’s approach is to meet our partners “where they are.” We seek to find the complementary balance of organizational experience and operational strength to support our partner’s success. PSW’s diversified business portfolio includes payer network operations, accountable care models, and advisory and management solutions; this collective work accounts for more than 400,000 member lives with a clientele of hospital systems, payers, vendors, and provider practices.

In 2017, PSW created its first Accountable Care Organization (ACO): NW Momentum Health Partners (NWMHP). NWMHP was created to give our partner providers the ability to join a single network and engage in new innovative Federal payment models. Since then, NWMHP has participated in several CMS Innovation Center models: the Next Generation ACO Model, the Bundled Payments for Care Improvement Advanced (BPCI) Model, Global and Professional Direct Contracting (GPDC) Model, and the ACO Realizing Equity, Access, and Community Health (REACH) Model.

In 2018, PSW began its partnership with MultiCare Health System and MultiCare Connected Care (MCC). MCC was developed to be the Clinically Integrated

Network (CIN) for MultiCare Health System and participate as an ACO in the Medicare Shared Savings Program (MSSP). MCC's ACO includes all MultiCare Health System hospitals and several other provider organizations throughout Washington State.

ACCOUNTABLE CARE IS IMPROVING CARE DELIVERY AND LOWERING COSTS

Through our vast experience, we have seen how accountable care (also called alternative payment models) delivers coordinated care that best meet the needs of people, particularly those with chronic conditions. Accountable care delivery holds providers responsible for the cost of care and health outcomes. As opposed to a fee-for-service system where the incentives are aligned toward greater volume, accountable care focuses on healthier populations and people.

Accountable care efforts have shown that holding clinicians responsible for total cost of care and patient outcomes improves care, expands access, and saves money for Federal programs:

- Accountable care improves care experiences by holding providers responsible for patient outcomes and creating cash flow through up-front or population-based payments that providers can use to invest in tailored care management programs, including for the chronically ill. Accountable care strategies including care coordination, care transitions programs (smoothing the transition from hospital to home for example) and care management for medically complex patients improve people's care experiences.¹
- Accountable care expands access to care, for example, increasing weekend and evening hours appointments, using data to identify gaps in care, and developing relationships with community providers and social needs organizations to improve health outcomes and address social determinants of health.²
- By incentivizing preventative care and reducing wasteful spending, accountable care saves money. Advanced APM Accountable Care Organization (ACO) portfolio (ACOs that take on two-sided risk, including two-sided risk Medicare Shared Savings Program and CMS Innovation Center ACOs) saved \$4.2 billion in traditional Medicare in 2022,³ and a total of \$8.4 billion in gross savings after taking into account spillover effects in Medicare Advantage.

CHRONIC CARE MANAGEMENT SUCCESSES IN ACCOUNTABLE CARE DELIVERY

PSW's Chronic Care Management (CCM) program, overseen by the chief medical officer (CMO) and chief nursing officer (CNO), is specifically designed to enhance the quality of life for patients dealing with chronic health conditions. Its primary objectives are to reduce health disparities, minimize unnecessary health-care costs, and align with value-based reimbursement systems. This initiative places a strong emphasis on empowering patients to take charge of their health through active engagement with primary care services.

The CCM program is particularly geared towards individuals with chronic diseases who require support for self-management to improve health outcomes. It operates within home settings, where patients or their designated representatives assume responsibility for self-care under professional guidance. Notably, the program takes a proactive approach by identifying patients with poorly controlled chronic conditions or significant negative impact of social determinants of health, with the overarching goal of enhancing patient well-being and health outcomes.

One of the program's core strategies is to foster long-term positive outcomes by ensuring patients and their caregivers possess the necessary knowledge and skills to identify and address health concerns promptly. A registered nurse plays a pivotal role in this process by developing and executing personalized care plans. This nurse collaborates closely with a multidisciplinary team comprising physicians, licensed practitioners, social workers, discharge planners, pharmacists, and other health-care professionals as needed.

Services provided through the CCM program are highly individualized, tailored to support patients with chronic conditions in improving their overall health and well-being. The program places a strong emphasis on patient education and empowerment for effective chronic disease management and self-care. Through a collabo-

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7347295/>.

² https://accountableforhealth.org/wp-content/uploads/2024/02/BRG_ImprovingAccessThroughValueBasedCare2024.pdf.

³ <https://www.naacos.com/assets/docs/pdf/2023/NAACOS2022ACOSavingsResource.pdf>.

rative team approach involving the patient, nurse care manager (NCM), and primary care provider (PCP), the program strives to achieve the patient's specific health goals.

Additionally, comprehensive documentation of services follows stringent National Committee for Quality Assurance (NCQA) requirements. Participation in the Complex Care Management Program is voluntary, with patients having the option to opt out at any time, provided they meet the established enrollment criteria. This comprehensive approach ensures that patients with complex health issues receive holistic care tailored to their individual needs, ultimately aiming for improved health outcomes and quality of life.

Patient Example

A patient with multiple health issues, including congestive heart failure, experienced setbacks due to hospitalizations for sepsis and pneumonia. Despite adhering to prescribed medications, their symptoms worsened at home. After enrolling into a PSW ACO care management program, a PSW nurse care manager began engaging with the patient and recognized critical signs. The nurse care manager immediately took action by contacting the primary care physician and recommending daily monitoring of weight and blood pressure. With the remote monitoring and PCP's adjusted medication regimen, the patient rapidly improved within 2 days, avoiding further complications. This success highlights the vital role of ACO care management programs in providing timely support and interventions for patients dealing with complex health issues, enabling them to recover at home.

ACO Successes

NWMHP and MCC have played a pivotal role in transforming health-care delivery and improving patient outcomes in Washington State, resulting in significant cost savings for Medicare. Through their innovative and patient-centered approaches, these ACOs have collectively saved \$120 million for Medicare while maintaining an impressive average quality score of 96 percent and an average savings rate of 4.5 percent from 2017 to 2022.

NWMHP's emphasis on accountable care has led to notable advancements in patient outcomes across the State. By prioritizing coordinated care initiatives, they have streamlined care transitions, reduced hospital readmissions, and bolstered preventive care services. NWMHP has partnered with independent providers and Critical Access Hospitals alike to expand access to care and benefits to Medicare beneficiaries. Moreover, NWMHP's proactive approach to preventive care has resulted in increased utilization of wellness visits and recommended screenings, fostering early detection and management of health conditions.

Similarly, MCC's commitment to accountable care has yielded positive outcomes for patients throughout Washington State. Through targeted programs focusing on chronic disease management, MCC has empowered patients to better manage their conditions, leading to improved health outcomes and reduced health-care expenditures. The emphasis on preventive screenings, including mammograms and flu vaccines, has promoted proactive health management and wellness among beneficiaries. Additionally, MCC's efforts in care coordination have facilitated smooth transitions for patients navigating different care settings, ensuring continuity of care and optimal patient experiences.

The combined achievements of NWMHP and MCC underscore their dedication to delivering high-quality care while driving cost savings for Medicare. Their success stories exemplify the transformative impact of accountable care models in enhancing care coordination, promoting preventive services, optimizing chronic disease management, and ultimately, improving patient outcomes and health-care affordability in Washington State.

FEDERAL POLICY CAN DRIVE BETTER CARE FOR CHRONICALLY ILL PEOPLE

The Medicare Access and CHIP Reauthorization Act (MACRA) has been instrumental in driving participation in accountable care that improves care for people. MACRA included incentives for participation in two-sided risk models, where providers can share in savings if they beat spending targets while improving quality or repay losses if they exceed those targets. Participants also received an incentive payment for participating in a two-sided risk arrangement, known as the advanced APM bonus. Those incentives served as a powerful motivator to grow accountable care and allowed participants to reinvest into the health care delivery system to expand access, improve care, and support our clinical network. As a result, substantially more clinicians today, including specialists, are participating in accountable

care as compared to before MACRA was enacted. ACO participation in the Medicare Shared Savings Program has more than doubled, from 220 ACOs providing care to fewer than 5 million Medicare beneficiaries in 2012,⁴ to 480 ACOs providing care to nearly 11 million aligned beneficiaries in 2024.⁵

While accountable care has shown progress toward the goals of better outcomes and lower costs, additional work is necessary to drive change to the way care is delivered in Medicare and for other payers. Now, nearly 10 years after MACRA's passage and over a decade into our ACO and APM experience, we know more about what incentives work to drive participation in APMs. Specifically, we would recommend:

- Extend the advanced APM bonus in the short term to demonstrate Congress's bipartisan continued commitment to ensuring better care for patients in traditional Medicare.
- Restructure the bonus in the longer term to strengthen that commitment, delinking advanced APM bonuses from volume of services provided and shortening the time between payment and performance (which is currently a 2-year delay).
- Focus on advanced APM policies that simplify and support provider participation and create clear advantages for participating in an advanced APM.
- Strengthen the data infrastructure to support accountable care and population health.

INCENTIVES FOR BENEFICIARIES TO ENGAGE

Creating incentives for beneficiaries to engage with ACOs is crucial to ensuring that the intended programs developed by ACOs have a true impact on the population. Cost sharing incentives, for example, can increase access services that otherwise might be avoided or forgone. In Washington State, Columbia County Health System saw this as they embarked on a journey to provide greater support to their patients at risk of or diagnosed with chronic obstructive pulmonary disease (COPD). Recognizing the challenges faced by these individuals, Columbia County Health System developed a comprehensive program in collaboration with their chronic care management efforts.

This program was designed to offer additional support and resources, including regular nurse consultations, enhanced care coordination, increased primary care visits, and facilitated access to community-based and State-funded services to address social determinants of health. However, despite the immense potential of this program to improve patient outcomes and quality of life, Columbia County Health System encountered a significant obstacle: low enrollment among Medicare beneficiaries.

The primary deterrent to enrollment was the financial burden imposed by coinsurance payments, rendering many beneficiaries unable to afford these health-care services. It was evident that without addressing this barrier, the program's impact would be severely limited, denying vulnerable populations access to the care they desperately needed.

In response to this challenge, Columbia County Health System, with the support of our ACO, implemented the ACO REACH cost-sharing waiver. This strategic decision to waive coinsurance payments proved to be a game-changer. By alleviating the financial burden on beneficiaries, we witnessed a remarkable surge in program enrollment.

The waiver not only facilitated greater participation but also translated into tangible improvements in patient outcomes. Patients with COPD who previously struggled to access care now had the means to engage proactively in managing their health. This translated into increased use of primary care, improved disease management, and ultimately, enhanced quality of life for these individuals.

The success story of Columbia County Health System's COPD program underscores a fundamental principle: when we remove financial barriers and create incentives for engagement, we unlock the full potential of ACO initiatives to deliver transformative health-care solutions. It is imperative that we continue to explore

⁴ <https://www.federalregister.gov/documents/2014/12/08/2014-28388/medicare-program-medicare-shared-savings-program-accountable-care-organizations>.

⁵ <https://www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024>.

and implement innovative strategies, such as cost-sharing waivers, to ensure equitable access to quality care for all beneficiaries.

SUPPORT PROVIDER PARTICIPATION IN SUSTAINABLE, EFFECTIVE ACCOUNTABLE CARE

ACOs have supported and improved care for chronically ill individuals for over a decade. Through two main avenues, the Medicare Shared Savings Program and the ACO portfolio at the CMS Innovation Center, participants in these total cost of care models, where providers are accountable for population health and cost, have consistently demonstrated savings and care improvements.

More can be done to support these models as well. In the Medicare Shared Savings Program, CMS can continue to develop options with greater levels of financial risk and reward, such as a full risk ACO that was included in the Value in Health Care Act, introduced earlier this year. In addition, Congress and CMS should work to ensure that there are clear advantages under MACRA to participating in MSSP, disentangling MSSP participants from burdensome MIPS requirements.

The ACO portfolio at the CMS Innovation Center has been a mainstay of that portfolio since the Innovation Center's creation and continuing across administrations with bipartisan support. Congress should support continued operation of ACO models at the CMS Innovation Center that support the transition to population-based payments, experiment with new waiver flexibilities, and allow greater pursuit of coordinated care strategies that support patient care.

CONCLUSION

I thank the Committee for the opportunity to testify today. On behalf of PSW and MultiCare Care Connected, we look forward to continuing to work with you to advance the United States health care delivery system to get better outcomes for patients.

Melanie's Affiliations

Accountable for Health (A4H)—board member
National Association of ACOs (NAACOS)—board member and chair-elect
America's Physician Groups (APG)—board member
Health Care Transformation Task Force (HCTTF)—board member

QUESTIONS SUBMITTED FOR THE RECORD TO MELANIE MATTHEWS, MSN

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. Advanced Alternative Payment Models (AAPMs) hold significant promise as a means of driving improved value while ensuring appropriate and targeted stewardship of Federal Medicare dollars for both beneficiaries and taxpayers.

What specific steps should Congress or CMS take in order to improve uptake of these models, including for specialties with low participation rates?

Answer. To improve uptake of these models, Congress should pass legislation that provides clear, strong incentives for the move to accountable care. For example, Congress should extend the alternative payment model (APM) incentive payment which helps providers address the start up costs and ongoing costs associated with participating in these models, including hiring staff, investing in health IT and standing up care management programs. Congress should also make clear that the Merit-based Incentive Payment System (MIPS) is less attractive than APM participation. Today, the maximum MIPS potential bonus is 9 percent while the advanced alternative payment model bonus is 1.88 percent. These programs are reversed if the goal is to increase uptake in alternative payment models.

Congress should also review the qualifying thresholds to obtain APM status. MACRA established revenue/performance thresholds—known as Qualifying APM Participant (QP) thresholds—that APM participants must meet to qualify for incentives. These statutory levels, which increase over time, have proven unrealistic relative to the real-life experiences of clinicians. Congress has previously adjusted the QP thresholds in 2020, 2022, and 2024.

The Value in Health Care Act ensures that qualifying thresholds remain attainable to promote program growth by freezing them at 50 percent for 2 years and giving the Centers for Medicare and Medicaid Services (CMS) authority to adjust thresholds through rulemaking and set varying thresholds for more targeted models

where participants (*e.g.*, specialists) cannot meet the existing one-size-fits-all thresholds.

Last year, CMS also proposed making QP determinations at the individual NPI level instead of the APM entity. This policy was not finalized due to broad stakeholder concerns, but CMS has expressed interest in revisiting this change.

While the current QP thresholds can make it difficult for some ACOs to include specialists, there is concern that only making QP determinations at the individual level would further discourage specialist participation in ACOs.

As uptake of APMs continues to underperform original projections the agency should use a determination process that will maximize the number of QPs and promote growth in APMs.

Question. What specific flexibilities would help Accountable Care Organizations to improve patient care quality and reduce costs, and what steps could Congress take to advance these types of flexibilities?

Answer. MIPS—Reduce program complexity by ensuring that clinicians in APMs are not required to engage in duplicative quality reporting efforts. Emphasize that MIPS should prepare clinicians for and encourage adoption of APMs.

Interoperability and use of CEHRT—CMS should repeal policies changing the CEHRT requirements for MSSP ACOs and other APM participants in 2025. In April, over 100 ACOs and dozens of health-care associations wrote to CMS outlining how PI changes finalized in the 2024 Medicare Physician Fee Schedule will result in significant increases in burden, especially for small practices.¹

Digital Quality—Direct CMS to pilot test new digital quality measurement to identify key challenges and unintended consequences. Congress should provide incentives to participate in pilot tests, such as exemptions from existing reporting requirements.

MSSP—(1) Remove the high or low revenue-based designation in MSSP that penalizes certain ACOs, especially those including rural and safety net providers, (2) establish guard rails for CMS to ensure that the process to set financial benchmarks is transparent and appropriately accounts for regional variations in spending, to prevent arbitrary winners and losers, (3) direct CMS to establish a voluntary, full-risk track MSSP, and (4) expand the ACO Primary Care Flex model to all ACOs to ensure that more clinicians can take advantage of prospective population-based payments for primary care.

Waivers—Direct CMS to establish a common set of waivers for APMs, incorporating successful waivers from the Next Generation ACO Model and the ACO REACH Model into MSSP.

Chronic Care Management (CCM)—While APMs offer opportunity to allow providers to reduce beneficiary cost sharing to ensure patients receive enhanced care management, we encourage the committee to look at legislative options to waive the beneficiary coinsurance related to CCM.

GAO Report on Parity—Evaluate the potential of parity between APMs and Medicare Advantage (MA) so policymakers can seek greater alignment between the programs to ensure that both models provide attractive, sustainable options for innovating care delivery, and to ensure that APMs do not face a competitive disadvantage.

CMMI—Ensure that promising aspects of innovative models have a more predictable pathway for becoming permanent.

Question. Artificial intelligence (AI) has the potential to mitigate administrative burden and enhance health-care quality, including in the context of Medicare. That said, some clinicians have raised concerns around the program's inability to keep pace with AI-enabled tool development through its coverage and payment policies, undercutting access, especially for smaller practices.

What use cases for AI-enabled tools and technologies seem most promising in the context of clinician care?

Answer. AI-enabled tools and technologies offer numerous promising use cases in the context of clinician care. One area is quality gap closure, where AI systems can

¹ https://www.naacos.com/assets/docs/pdf/2024/AMASignonLetter_PICEHRTChangesAPMs041024.pdf.

efficiently communicate with patients and schedule appointments on their behalf, ensuring timely and seamless health-care delivery. This not only improves patient experience but also optimizes clinic workflows.

Another valuable application is in annual wellness visits, where AI tools can streamline the process, making it more comprehensive and personalized. This ensures that preventive care measures are effectively implemented, leading to better health outcomes.

Chronic disease monitoring is another promising area where AI shines. By continuously monitoring patients and sending reminders about necessary tests and visits, AI tools empower patients to manage their conditions more effectively while providing clinicians with real-time data for proactive intervention.

Additionally, AI can support clinicians in providing accurate and timely differential diagnoses through clinical decision support and chart review functionalities. This not only enhances diagnostic accuracy but also aids in treatment planning.

One of the notable benefits of AI-enabled tools is the potential for reducing administrative expenses significantly. The automation of administrative tasks frees up resources that can be redirected towards patient care, ultimately improving the overall quality of health-care delivery.

Lastly, AI has the potential to enhance documentation practices by providing more robust and accurate documentation of patient encounters. This not only improves the quality of medical records but aids in research and analysis for improvement in health-care practices.

Question. What steps should CMS and Congress take to ensure adequate coverage and reimbursement for appropriate AI-enabled tools in this context?

Answer. To ensure adequate coverage and reimbursement for appropriate AI-enabled tools in the context of clinician care, both CMS and Congress can take several proactive steps.

Establish programs and incentives: Implement programs and incentives that encourage the use of AI-enabled tools in health-care settings. These programs can be tracked through auditing processes to ensure proper utilization and effectiveness. Incentives could include financial rewards, performance-based bonuses, or accreditation benefits for clinics and providers adopting AI tools effectively.

Develop specific billing codes: Work collaboratively to develop specific billing codes that reflect services leveraging AI technologies. For example, for tools used in completing assessments like the PHQ-9 (Patient Health Questionnaire-9) with patients, there could be dedicated billing codes that allow for appropriate reimbursement. These codes should be designed to accurately capture the value and complexity of AI-enabled services provided.

Collaborate with industry stakeholders: Engage with industry stakeholders, including AI developers, healthcare organizations, and professional associations, to gather insights and best practices for integrating AI tools into clinical care. This collaboration can help identify opportunities for coverage and reimbursement improvements and address any regulatory or policy barriers hindering the adoption of AI technologies.

Regular review and updates: Establish a framework for regular review and updates of coverage and reimbursement policies related to AI-enabled tools. This ensures that policies remain current with advancements in technology and health-care practices, allowing for agile adjustments to support appropriate reimbursement for innovative AI solutions.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. The Center for Medicare and Medicaid Innovation (CMMI) receives \$10 billion in mandatory funding every decade. The nonpartisan Congressional Budget Office (CBO) has found that CMMI has not lowered Medicare spending. Separately, CBO has found the Medicare Shared Savings Program (MSSP) was not a factor in the slower growth of Federal health-care spending.

Are the spending impacts on Medicare from CMMI and MSSP each validated by an independent, third-party organization? If not, why would that be important?

Answer. There have been limited independent, third-party organizations who have assessed the impact of MSSP. Studies conducted by MedPAC,² the National Association of ACOs,³ and researchers at Harvard University,⁴ have all concluded net savings to Medicare. In fact, in MedPAC's 2020 report to Congress the Commissioners estimated that ACO models accounted for a 1- or 2-percent slower growth rate in spending. The report from the commission goes on to say, "Although the estimated savings from these models are modest, they surpass those achieved by a wide variety of care coordination models Medicare has tried."

It is important to bolster the ability for independent third-party organizations to evaluate the impact of CMMI and MSSP. The current approaches that CBO and CMMI uses to assess programs may not capture the full impact of the model. For example, current approaches are ineffective in quantifying the impact of health-care delivery changes. Providers in APMs deliver care management improvements for their patient populations, not just the patients aligned to the APM. This "spillover effect" creates savings accrued to non-model patients. Similarly, it is increasingly challenging to evaluate models against a population that is not in any value model. This counterfactual is difficult with Medicare alternative payment models because so many traditional Medicare patients are in at least one, if not multiple, models. It's hard to find a population on which to make a true comparison of no value-based care interventions.

The proliferation of value, while a testament to its success, will create challenges in assessing its impact. Providers in Medicare APMs have been engaging in value-based arrangements with Medicaid, Medicare Advantage, and commercial payers. This ultimately drives system-wide changes that are not captured by single model evaluations.

In this vein, CBO has previously testified that ACOs may not have been the primary driver of lower health-care spending. However, a recent CBO report cited reductions in the growth of health-care spending is due to reductions in spending on patients with cardiovascular diseases due to better care management and increased use of technology.⁵ To those of us working to improve patient care, these findings are a direct result of value-based care. Care management and leveraging technology to support population health management are two core components of all APMs, yet these aspects are not measured as part of CBO reports or CMMI evaluations.

To support more independent, third-party organization research and to better demonstrate the impact of value, we recommend the following:

- CMMI should release more granular data on providers participating in these models. Even CBO has had to rely on the formal, published evaluations for its conclusions about CMMI models.
- CMMI and CBO should include a broader set of model aspects in its evaluation reports—such as provider satisfaction, beneficiary satisfaction, overlap with other models, potential spillover to practice change, and additional benefits or services provided to beneficiaries because of inclusion in the model.
- CMMI and CBO should consider how to assess quality improvements. As outlined by Congress, CMMI models should lower costs without sacrificing quality, improve quality without raising spending, or both lowering costs and improving quality. CMMI models should be deemed successful if they improve quality of care, even if they don't lower Medicare spending.

Question. In 2005, this committee held a hearing that I chaired titled, "Improving Quality in Medicare: The Role of Value-Based Purchasing." I said at the time that we do not want to overburden providers with reporting requirements. I went on to say that it is important to develop these health-care quality measures by consensus.

Do you feel reporting requirements are developed by consensus and do not overburden providers? If not, what actions should we take to reduce the burden?

Answer. MACRA created pathways for reducing provider burden by excluding all clinicians in advanced APMs from MIPS. This has been a strong nonfinancial incentive for providers to join APMs; however, we are concerned that CMS has removed

²https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch2_reporttocongress_sec.pdf.

³<https://www.naacos.com/assets/docs/pdf/ExecutiveSummaryStudyMSSPSavings2012-2015.pdf>.

⁴<https://www.nejm.org/doi/full/10.1056/NEJMsa1803388>.

⁵<https://www.cbo.gov/system/files/2023-10/59660-testimony.pdf>.

some of this burden reduction. In an effort to align ACOs and APMs reporting approaches with MIPS, CMS is now requiring:

- Advanced APMs to report the Promoting Interoperability (PI) category of MIPS instead of attesting to CEHRT use by clinicians in the APMs. This adds burden as it will require reporting of metrics that are not indicative of improved care. ACOs must be committed to information sharing to be successful in the model, so these requirements are duplicative and unnecessary.
- ACO reporting requirements to align with MIPS. The MIPS reporting requirements and scoring rules were created with a focus on individuals and small groups and have therefore caused a number of problems when applying to ACOs who are a collection of clinicians, hospitals, and other providers. This has resulted in expensive data aggregation and de-duplication work to report quality measures at the ACO level using MIPS measures, specifications and reporting types.
- ACOs to report electronic clinical quality measures (eCQMs) ahead of industry readiness, with a lack of full adoption of standards and interoperability impeding this effort.

Additionally, quality measures have not been designed to measure the care delivered in value arrangements. The quality measures that have been developed since the passage of MACRA have been focused on implementation in a fee-for-service system. Measures for APMs are then selected from the available FFS measures. For value-based care entities, the measure sets vary across programs and models, there are multiple reporting methods, and a misalignment with the measures sets used in MA and commercial value arrangements.

Fundamentally, we believe that this approach is flawed. Reporting for ACOs and other APMs should be the gold standard with MIPS structured to prepare clinicians for adopting APMs. To accomplish this, Congress should:

- Exclude all APMs from all MIPS, this will reduce program complexity by removing duplicative efforts.
- Direct CMS structure MIPS to prepare clinicians for transitioning to APMs.
- Direct CMS to exclude advanced APMs from all MIPS reporting categories, repealing the recently finalized rule requiring advanced APMs to report PI. Instead, CMS could require advanced APMs to attest to additional needed elements such as information blocking. Over 100 ACOs and dozens of stakeholders recently sent a letter to CMS requesting this change.⁶
- Direct CMS to develop measures specifically for APMs.
- Direct CMS to pilot test eCQMs and other digital quality measure approaches ahead of required implementation.

Question. In CBO's report on pilot programs supported through CMMI, only six of the 49 pilot program models saved money.

Are CMMI models effective at lowering total Medicare spending? Did the Comprehensive Primary Care Plus model save money?

Answer. The Innovation Center has been successful in testing innovative payment arrangements and increasing adoption of APMs. The successes of the Innovation Center are not always captured within current evaluation approaches. For example, CBO estimates that CMMI's activities increased direct spending by \$5.4 billion in the first 10 years and another \$1.3 billion by 2030.⁷ However, CBO's report focuses only on savings achieved and does not account for many aspects of value-based payment models such as provider burden relief, patient experience, clinical transformation, and the spill-over effect that occurs when providers apply value principles across all patient populations. The Innovation Center's evaluation criteria and criteria for model expansion have similar challenges. Congress should work with CMS to ensure that promising models have a more predictable pathway for being implemented and becoming permanent and are not cut short due to overly stringent criteria. Specifically, Congress should:

- Broaden the criteria by which CMMI models qualify for Phase 2 expansion. The criteria should consider if the model reduces provider burden, increases

⁶ https://www.naacos.com/assets/docs/pdf/2024/AMASignonLetter_PICEHRTChangesAPMs041024.pdf.

⁷ <https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf>.

patient satisfaction, offers additional benefits and services to patients that are not billed to Medicare, expands participation to more provider types, results in clinical care transformation, or is adopted in private sector value arrangements.

- Direct CMMI to engage stakeholder perspectives during APM development. The Innovation Center could leverage the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide input on models in development.

The Comprehensive Primary Care Plus (CPC+) model evaluation⁸ demonstrated that practices simultaneously participating in MSSP did achieve reductions in total expenditures even though the model did not reduce total Medicare expenditures after accounting for enhanced payments. CPC+ practices in the MSSP cohort were also found to have reduced acute inpatient expenditures by over 2 percent during the course of the model.

Given the positive interaction of CPC+ and MSSP, it is important to replicate this approach for all ACOs. Currently, ACOs in the REACH model can offer primary care capitation. The new ACO Primary Care Flex (PC Flex) Model, which will provide monthly, prospective, population-based payments for primary care practices in participating MSSP ACOs will replicate the success of CPC+ and MSSP together. However, it is disappointing that the model is limited to ACOs that are designated as “low revenue,” have selected prospective assignment, and begin a new agreement period beginning in 2025. This will significantly limit participation in the model since the majority of primary care providers currently participating in MSSP are in “high revenue” ACOs, including 67 percent of primary care physicians, 68 percent of NPs, 72 percent of PAs, 87 percent of RHCs, and 25 percent of FQHCs. To build on known successes, CMS should open the PC Flex model to all ACOs in MSSP.

Question. You stated in your written testimony that the “advanced APM Accountable Care Organization portfolio (ACOs that take on two-sided risk, including two-sided risk Medicare Shared Savings Program and CMS Innovation Centers ACOs) saved \$4.2 billion in traditional Medicare in 2022, and a total of \$8.4 billion in gross savings after taking into account spillover effects in Medicare Advantage.”

Are these figures validated by an independent, third-party organization? If so, by whom?

Answer. These savings numbers are derived from public use files CMS makes available and reflect the difference between CMS-generated benchmarks for a given year and an ACOs’ collective spending compared to those benchmarks.⁹

Recently, CBO released an updated report highlighting how several counterfactual studies have shown ACOs in the MSSP program are associated with net budgetary savings for the Medicare program.¹⁰ Many of CBO’s recommendations to increase ACO savings—increasing and extending current provider incentives, ensuring accurate financial benchmarks, improving patient engagement, and offering tools like primary care hybrid payments—are options that PSW and other stakeholders have previously discussed with Congress. We hope this report spurs additional interest in these topics from Capitol Hill.

Question. A common concern from Iowa providers is the lack of preparation and notice for final payment rules from CMS. When final payment rules are set a couple of months or less from the start of the payment rule’s implementation date, providers do not have time to prepare or adjust to new payment policies and administrative requirements. This includes changes to value-based care efforts.

Should there be a longer preparation period (e.g., 6 months, 1 year) for providers to adjust to new payment policies and administrative requirements under Medicare? What effect would that have? Alternatively, should payment policies and adminis-

⁸ PY4 evaluation: <https://www.cms.gov/priorities/innovation/data-and-reports/2022/cpc-plus-fourth-annual-eval-report>.

Summary: <https://www.cms.gov/priorities/innovation/data-and-reports/2022/cpc-plus-fourth-annual-report-findings>.

PY5 (final) evaluation: <https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report>.

Summary: <https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fg-fifth-annual-eval-report>.

⁹ <https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-spp-acos/data>.

¹⁰ <https://www.cbo.gov/publication/60213#footnote-038-backlink>.

trative requirements remain consistent for more than 1 year except for newer input data (e.g., inflationary or economic factors)?

Answer. There should be longer preparation periods for some new policies. Certain small changes or changes in response to ACO participant challenges could be implemented more rapidly, while other significant changes or payment cuts have at least a year-long preparation period before they are put in place. This would allow provider organizations a reasonable amount of time to implement necessary operational changes or carefully consider strategic decisions that would impact their participation in Advanced Alternative Payment Models (AAPM).

One example of this is the impact of participation in the Medicare Shared Savings Program (MSSP) based on the timing of the Medicare Physician Fee Schedule rule. Currently, MSSP ACOs must submit to CMS their list of participating providers who have signed an agreement to participate in MSSP by the beginning of August. This submission ultimately determines the decision for the AAPM that a provider organization will participate in for the upcoming year. However, the final Medicare Physician Fee Schedule rule is typically not released until November with policy changes that often affect MSSP for the upcoming year.

This can be a challenge for provider organizations looking to participate in AAPMs as these late policy changes make projections for potential performance highly unpredictable. Creating a sufficient preparation period before new policies are finalized will ensure that provider organizations are given a proper amount of time to evaluate the effects of those policies on their operations and financial stability.

Question. A 2023 RAND study of the Medicare Advantage Value-Based Insurance Design Model found the first 2 years of the model did not result in improved health outcomes or costs, but there was an improvement in the quality of care. This is similar to independent analyses of fee-for-service value-based models.

What is the scope of value-based contracts in Medicare Advantage and their effectiveness in reducing costs and improving outcomes?

Answer. Adoption of value-based contracts between Medicare Advantage plans and providers are reported informally to the Health Care Payment Learning and Action Network. Summary reports on the adoption of alternative payment model contracts for the past several years are available here: <https://hcp-lan.org/apm-measurement-effort/2023-apm/>.

Their effectiveness in reducing costs and improving outcomes would be accessible via the individual health plans—that data is not currently publicly available as far as we are aware.

In our experience, we are fully delegated for risk in Medicare Advantage, allowing us to support our providers across Medicare Advantage and Medicare ACOs. We are able to synthesize measures and operational workflows to ease the provider burden when participating in multiple programs. We have been successful in this space in reducing costs and improving outcomes for Medicare Advantage and Medicare ACO beneficiaries alike.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. The Medicare program accounts for about 20 percent of national health-care spending, and Medicare physician payments account for 26 percent of all national payments for physician and clinical services. Despite the enormous amount we spend on health care, health outcomes, especially for our seniors, are not better than comparable wealthy countries. In fact, the United States has the highest rate of people with multiple chronic conditions out of all high-income countries.

As the baby boomer generation ages, Medicare expenditures will only continue to rise. We must be looking at innovative ways to reduce costs for the government while improving health outcomes at the same time. One of these innovations is Accountable Care Organizations, or ACOs. An ACO is a group of health-care providers who voluntarily come together to provide coordinated, high-quality care for Medicare patients. By increasing coordination, ACOs help reduce duplication of services and prevent medical errors, leading to higher health outcomes. ACOs also help reduce costs by reinvesting a portion of the savings they generate into the Medicare trust fund. In Washington State, there are 44 ACOs serving more than 260,000 Medicare

beneficiaries. These ACOs saved \$104.5 million for Medicare in 2021 and 2022, which amounted to \$235 in savings per beneficiary.

This is the type of innovation that we need to consider as we tackle the problem of ballooning medical expenditures. We need to start moving away from volume-based care that prioritizes the quantity of services provided, to value-based care that prioritizes quality of care and increased health outcomes.

Do you agree that Medicare could see even more savings and improve the quality of care for seniors by encouraging more providers to join ACOs?

Answer. Yes. ACOs have demonstrated the ability to generate savings for Medicare and improve the health outcomes for the populations that they serve. By adopting policies, such as extending the Advanced Alternative Payment Model (AAPM) bonus, that encourage greater provider participation in ACOs, Medicare could see exponential growth in the savings generated by these programs.

Question. Are there any issues or roadblocks that are preventing more providers from joining ACOs?

Answer. There are several roadblocks to increased provider participation in ACOs. Some of the biggest roadblocks are:

- **Infrastructure and resources:** Participating in an ACO often requires robust infrastructure and resources to manage data, track performance metrics, and coordinate care effectively. Smaller practices or those with limited technological capabilities may find it challenging to meet these requirements, making ACO participation less feasible.
- **Regulatory and compliance burdens:** ACOs comply with complex regulatory requirements, including those related to data reporting, quality measures, and beneficiary communications. Navigating these regulatory requirements can be time-consuming and resource-intensive for providers, acting as a barrier to participation.
- **Incentive alignment:** Ensuring that incentives are aligned is essential for the success of ACO Models. Misaligned incentives or conflicting policy changes can create challenges in achieving shared goals and may discourage providers from joining or remaining actively engaged in an ACO.
- **Rural and underserved:** To improve access to health care in rural and underserved settings, Congress should create more pathways for providers in rural settings to adopt APMs. There are significant barriers to providers who are currently paid via cost-based reimbursement to be able to successfully participate in ACOs. In the last decade we have seen significant adoption among rural providers, with more than 4,400 Federally Qualified Health Centers (FQHCs), 2,200 Rural Health Clinics (RHCs), and 460 Critical Access Hospitals participating in MSSP or ACO REACH.

Question. What types of policies or programs should we be promoting to incentivize more providers to join ACOs?

Answer. There are many policy changes that would encourage greater participation in ACOs such as the Value in Healthcare Act, which would implement numerous policies that would incentivize greater participation in ACOs. These policies include the extension of the APM incentive payment, establishes guardrails for CMS to ensure that the process to set financial benchmarks is transparent and appropriately accounts for regional variations in spending, and removes the revenue-based designation in the Medicare Shared Savings Program (MSSP) that penalizes certain ACOs, especially those including rural and safety net providers.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. Too often our health-care system looks at patients' medical needs as separate and unrelated issues rather than looking at the full picture of someone's health.

Value-based care recognizes the importance of coordinating patients' care for better health outcomes. It both holds providers accountable for their services and rewards good patient care. Patient health-care services are not just boxes to be checked.

Accountable Care Organizations provide this type of care to over 593,000 Medicare beneficiaries in Texas. You have extensive experience in value-based care.

Can you elaborate on how alternative payment models like ACOs incentivize more personalized care for patients?

Answer. Alternative payment models like Accountable Care Organizations promote personalized care for patients through various strategies.

ACOs establish financial incentives based on performance against quality metrics, encouraging providers to deliver high-quality, personalized care to improve patient outcomes. By aggregating data and providing performance scorecards, ACOs enable providers to track their performance and make data-driven improvements, fostering a culture of continuous quality improvement.

Moreover, many ACO models offer benefit enhancements to patients, such as extended services or to support improved access to care. These can be in the form of beneficiary incentives to engage in care programs. This further supports personalized care initiatives by addressing specific patient needs and preferences.

Additionally, the Advanced Alternative Payment Model (AAPM) bonus allows for investment in infrastructure enhancements, such as additional staff or technology improvements. This investment supports personalized care initiatives like care management programs and interdisciplinary care teams, which work collaboratively to develop specific care plans tailored to individual patient needs.

Through these mechanisms, ACOs create an environment that incentivizes and supports personalized care delivery, leading to better health outcomes and enhanced patient satisfaction.

Question. How does coordinating care both improve the patient experience and reduce wasteful spending?

Answer. Coordinating care plays a vital role in improving the patient experience and reducing wasteful spending by optimizing health-care delivery and addressing Social Determinants of Health (SDOH).

Firstly, through ACOs, care management programs can identify trends within practice groups, such as the overutilization of emergency departments (ED) for conditions like urinary tract infections (UTIs). By providing information on these trends, ACO care teams collaborate with providers to implement strategies that reduce ED visits. For instance, educating patients on alternatives like telehealth for non-emergency conditions can redirect care to more appropriate and cost-effective settings, reducing wait times, improving patient satisfaction, and reducing unnecessary health-care expenditures.

Additionally, coordinating care involves addressing SDOH, such as housing instability, food insecurity, and lack of access to transportation. These factors significantly impact health outcomes and health-care utilization. By implementing programs that target SDOH, health-care organizations can improve patient health outcomes, reduce the need for acute care services, and ultimately lower health-care costs.

Coordinating care enhances the patient experience by ensuring timely and appropriate access to care while also curbing wasteful spending through targeted interventions that address both health-care utilization trends and SDOH.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. As part of the Merit-based Incentive Payment System (MIPS), physicians must be compliant in promoting interoperability as part of their reimbursement, which helps to facilitate the sharing of data between various providers.

I have long been an advocate for health IT initiatives that can improve efficiencies and reduce costs in the health-care system, and I believe that sharing information between providers through an interoperable network has immense upside, so long as there are safeguards to protect patient privacy and ensure taxpayer funds are spent appropriately.

However, there continue to be challenges to physicians meeting interoperability metrics, like information blocking for example in which an individual or entity impedes the delivery or utilization of an electronic health record, making interoperability impossible.

In your view, how have practices been impacted by information blocking?

Answer. Information blocking has had a profound impact on health-care practices, particularly smaller provider organizations that lack robust information technology (IT) resources. The burden of achieving interoperability often falls heavily on these entities as larger systems prioritize their own operational efficiencies. This dynamic can result in significant challenges and increased costs for smaller providers who must rely on outsourcing for building and managing interoperability solutions.

One of the key issues is the absence of dedicated programs to support smaller, community-based provider organizations. These entities, often consisting of independent primary care practices, face the dual challenge of meeting stringent reporting and data sharing requirements while lacking adequate funding to invest in the necessary IT infrastructure. This imbalance can lead to suboptimal patient care outcomes and hinder the ability of these providers to fully leverage digital tools for improved health-care delivery.

For instance, in communities primarily composed of small, independent primary care providers, the strain is palpable. These providers are essential pillars of local health-care ecosystems but are often constrained by financial limitations when it comes to adopting and maintaining interoperable IT systems. Consequently, they may struggle to meet regulatory demands, share patient data seamlessly, and offer high-quality, coordinated care.

To address these challenges effectively, it's crucial to establish a supportive program that provides funding and resources specifically tailored to the needs of smaller provider organizations. By offering financial assistance and guidance for IT investments, such a program can empower these providers to enhance their interoperability capabilities, streamline data sharing processes, and ultimately improve patient outcomes across communities.

Question. Are you aware of instances in which the timeliness or quality of the care physicians are able to provide patients has been impacted by a limited ability or complete inability to access electronic health records?

Answer. The limited ability or complete inability to access electronic health records (EHRs) can indeed impact the timeliness and quality of care that physicians are able to provide to patients. Specifically, instances regarding Rural Health Clinics (RHCs) and their inability to submit CPT II codes in traditional Medicare can have a substantial impact.

When RHCs are restricted from submitting these codes for quality metrics, it creates a skewed perception that their outcomes are poorer compared to non-RHC groups. However, this discrepancy doesn't accurately reflect the care provided. It leads to duplicated efforts and adds a significant overhead and administrative burden on these rural systems, diverting valuable resources away from patient care.

Moreover, these limitations in funding and resources can have broader repercussions. Patients may perceive a lack of comprehensive care in rural areas and feel compelled to seek treatment in urban centers where access to advanced health-care services may be perceived as better. This migration of patients towards urban areas due to perceived gaps in care further strains the health-care system and can result in individuals who cannot afford such travel opting to forgo necessary medical attention altogether.

This situation underscores the critical importance of addressing barriers to EHR accessibility and interoperability, particularly for rural health-care settings. Investing in technology infrastructure, providing adequate funding and support for rural providers to implement and maintain EHR systems, and ensuring standardized reporting mechanisms can all contribute to improving the timeliness and quality of care delivered to patients in these underserved areas. Such efforts can also help mitigate the administrative burdens that currently hinder optimal patient care in rural healthcare settings.

Question. Furthermore, beyond information blocking, what other challenges persist in physicians accessing patients' health information electronically despite the billions of dollars spent to implement electronic health IT and interoperability?

Answer. Several challenges persist in physicians accessing patients' health information electronically despite significant investments in electronic health IT and interoperability.

One major challenge is the exorbitant cost associated with electronic medical records (EMRs). While EMRs are essential for digital health information manage-

ment, their initial implementation and ongoing maintenance expenses can be high and difficult to maintain. Additionally, the need for customization to suit specific workflows or requirements further drives up costs, creating financial barriers for smaller providers.

In rural communities, another significant challenge emerges due to reliance on larger health systems to purchase the technology. This reliance can create a monopoly in the market, where rural providers are limited to the options and functionalities offered by the dominant systems. As a result, these providers may not have access to tailored solutions that address their unique patient population or operational needs, impacting their ability to effectively leverage electronic health information for better patient care.

Addressing these challenges requires a multifaceted approach. Initiatives aimed at reducing the cost of EMRs, such as incentivizing standardized systems or providing subsidies for implementation, could make these technologies more accessible to a broader range of providers. Investments could also be made in this area by developing programs that provide a greater level of funding to small and rural providers attempting to meet the interoperability requirements.

QUESTION SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. I am working on a bill to relieve providers excelling in the Medicare Shared Savings Program (MSSP), from prior authorization (PA) requirements in MA. The bill rewards providers in Accountable Care Organizations (ACOs) that generate savings for Medicare by granting an exemption from PA requirements for their MA beneficiaries. If an insurer believes there is a rationale for maintaining PA in such instances, this bill would require them to seek prior approval from the Centers for Medicare and Medicaid Services. I would welcome your thoughts and comments on this idea.

Answer. There has been great discussion as to the administrative burden that the prior authorization process imposes on providers. We recognize the burden imposed to the providers as well as to the beneficiaries who see the process as a potential impediment or barrier to timely access to care. In the worst case scenario, prior authorization requirements can sometimes lead to the delay or denial of medically necessary care that compromises the outcome of a patient.

The Medicare Advantage program utilizes prior authorizations as a means to ensure that certain designated services meet established criteria before approval. This allows the Medicare Advantage Organization to safeguard against unnecessary procedures and treatments, reduce the risk of inappropriate or ineffective care, and encourage providers to explore equally effective but less costly alternative treatment options. By ensuring that efficacious quality care is being approved for delivery, Medicare Advantage plans help improve beneficiary outcomes—but only if the prior authorization process is efficient and effective.

We view the proposal to exempt well performing MSSP providers from all Medicare Advantage prior authorizations as ambitious and innovative, but potentially harmful to operations. The burden of knowing who is in or who is out of the program at the provider level at any given time provides additional abrasion and could consume resources that could otherwise be spent on investments in interoperability of the prior authorization process. Also, this approach would exempt a provider from all prior authorization requirements which may not be the most effective approach. A provider may be a successful MSSP participant without having made the same cost-effective, high-quality decisions for treating all conditions across the board. This exemption may be more effective at reducing provider burden while still managing cost by building an structure where a provider must apply for this exemption that is approved by a decision-making body. The decision-making body could then review the provider's practices and determine if an exemption should be offered for certain conditions or for the provider's entire range of practice.

If carried out effectively, this exemption would be an additive, nonfinancial incentive for providers to join ACOs and offer more streamlined access to their practices that meet care coordination and utilization standards. Tying the qualification to advanced APM eligibility could also help to standardize some of the nonfinancial incentives available for clinicians that choose to participate in APMs.

QUESTIONS SUBMITTED BY HON. MARSHA BLACKBURN

Question. It is important that Congress continue to promote policies that accelerate the movement toward alternative payment models (APMs). The Consolidated Appropriations Act of 2024 included a 1-year extension of the incentive payments for participation in eligible APMs at a reduced rate of 1.88 percent.

How will the continuation of the APM incentive payments help promote the movement toward value-based care? What can Congress or CMS do to encourage more physicians, especially specialists, to adopt APMs?

Answer. The continuation of the APM incentive payments will help providers invest in infrastructure that will allow them to be successful in an APM. Many of our small, independent providers used the APM incentive to help them pay staff wages and keep their doors open throughout the pandemic. Now, providers who have been able to stabilize their revenue can use the incentive payment to invest in new technology or additional resources that help them care for the community.

Congress and CMS could encourage greater APM participation by reinstating the full APM incentive payment and promoting policies that integrate specialists into ACOs. These policies would also need to redesign the requirements to achieve the APM incentive to account for specialists. Currently, ACOs with specialists in their network are unable to meet the thresholds required for the APM incentive payment. By developing a long-term APM incentive solution that accounts for specialists alongside primary care, Congress and CMS would see an increase in participation and in investments toward improving the health outcomes of patients.

Question. Every year, we see an alarming decline in physicians offering essential care services. This trend is partly fueled by soaring costs for practices, already high yet constantly increasing administrative burden, and low reimbursement rates, often well below the cost of providing care.

How has the cost of providing lifesaving care changed over the years for your practice, and how has the payment for those services caught up or not caught up?

Answer. The cost to provide lifesaving care has continued to increase over the years. The years following the pandemic have been especially challenging with the combination of increased pricing and struggle to maintain resources. The payment for these services have not kept up, causing numerous independent providers to close their doors or sell to a larger organization. Without a payment system that maintains pace with increasing costs and incentives such as the APM incentive payment to drive provider participation in APMs, we will continue to see a high rate of closure among independent providers. Many of our providers have relied on the APM incentive payment to keep their doors open through the pandemic. It is crucial to support the Value in Healthcare Act to extend important policies such as the APM incentive payment.

Question. How does the yearly scramble to delay or reduce CMS payment cuts to the PFS impact your ability to plan for the future? What would it mean for you and practices like you if these cuts were fully implemented and not scaled back?

Answer. The yearly scramble to mitigate CMS payment cuts to the Medicare Physician Fee Schedule has a substantial impact on our ability to plan for the future. The changes in the Medicare Physician Fee Schedule often dictate if a provider's participation in an ACO will be financially viable and impacts the resources that a provider must invest in to participate. With how late in the year these policy changes are released, providers are forced to have already signed contracts to participate in ACOs or made the decision to not participate for the upcoming year by the time the changes are released. This makes it near impossible to accurately project the financial viability of ACO participation and poses a substantial barrier to increased provider participation. Also, if many of these large proposed cuts are not scaled back due to our efforts, independent providers would not be able to maintain pace with rising costs and would be forced to shut their doors. Our organization spends a great deal of time with our advocacy groups to mitigate the payment cuts, but this takes time and resources away from our original mission to enhance the patient experience and improve the quality of care for those that we serve.

Question. As a value-based purchasing program, MIPS was supposed to reward physicians who achieved quality and cost-efficient care. However, for years physicians have raised concerns about the program, including that it increases administrative burden and does not accurately capture quality.

What has been your experience with MIPS and the administrative burden that it entails?

Answer. Due to its complexity, one of the many advantages to participating in APMs is the opportunity to be excluded from MIPS reporting. We believe it is essential that APM providers continue to have the opportunity to be excluded from MIPS. However, recent policy changes in the Physician Fee Schedule rule are attempting to impose burdensome MIPS reporting elements, such as reporting Promoting Interoperability, onto APM providers. This increased burden has no impact on the quality of care that is provided to patients.

Question. Is it time to consider replacing the program with a more valuable alternative? If so, what are some of the program's benefits that should be considered when designing its replacement?

Answer. A valuable alternative to MIPS already exists in the form of APMs. We support reducing program complexity by mitigating the duplicative work that providers engage in when participating in an APM. This would be accomplished by maintaining that APM providers be excluded from MIPS reporting and ensuring that new policy changes do not impose elements of MIPS reporting onto APM providers. Future reforms to MIPS should be used to prepare providers for participation in APMs and encourage them to transition from MIPS to APMs. A clear direction with clear incentives must be outlined for the pathway from MIPS to APM participation for providers, allowing them to adjust their efforts accordingly.

Question. Part of the Physician Fee Schedule's MIPS program measures interoperability, which is impeded by information blocking by providers, vendors, or others wanting to hoard patient data, which can affect MIPS performance and reduce reimbursement to providers.

How have your practices been impacted by information blocking?

Answer. Information blocking has had a profound impact on our health-care practices, particularly smaller provider organizations that lack robust information technology (IT) resources. The burden of achieving interoperability often falls heavily on these entities as larger systems prioritize their own operational efficiencies. This dynamic can result in significant challenges and increased costs for smaller providers who must rely on outsourcing for building and managing interoperability solutions.

One of the key issues is the absence of dedicated programs to support smaller, community-based provider organizations. These entities, often consisting of independent primary care practices, face the dual challenge of meeting stringent reporting and data sharing requirements while lacking adequate funding to invest in the necessary IT infrastructure. This imbalance can lead to suboptimal patient care outcomes and hinder the ability of these providers to fully leverage digital tools for improved health-care delivery.

For instance, in communities primarily composed of small, independent primary care providers, the strain is palpable. These providers are essential pillars of local health-care ecosystems but are often constrained by financial limitations when it comes to adopting and maintaining interoperable IT systems. Consequently, they may struggle to meet regulatory demands, share patient data seamlessly, and offer high-quality, coordinated care.

To address these challenges effectively, it's crucial to establish a supportive program that provides funding and resources specifically tailored to the needs of smaller provider organizations. By offering financial assistance and guidance for IT investments, such a program can empower these providers to enhance their interoperability capabilities, streamline data sharing processes, and ultimately improve patient outcomes across communities.

Question. Have you had experiences where your ability (or inability) to access health records has impacted the timeliness or quality of the care you are able to provide your patients?

Answer. The limited ability or complete inability to access electronic health records (EHRs) can indeed impact the timeliness and quality of care that physicians are able to provide to patients. Specifically, instances regarding Rural Health Clinics (RHCs) and their inability to submit CPT II codes in Traditional Medicare can have a substantial impact.

When RHCs are restricted from submitting these codes for quality metrics, it creates a skewed perception that their outcomes are poorer compared to non-RHC groups. However, this discrepancy doesn't accurately reflect the care provided. It

leads to duplicated efforts and adds a significant overhead and administrative burden on these rural systems, diverting valuable resources away from patient care.

Moreover, these limitations in funding and resources can have broader repercussions. Patients may perceive a lack of comprehensive care in rural areas and feel compelled to seek treatment in urban centers where access to advanced health-care services may be perceived as better. This migration of patients towards urban areas due to perceived gaps in care further strains the health-care system and can result in individuals who cannot afford such travel opting to forgo necessary medical attention altogether.

This situation underscores the critical importance of addressing barriers to EHR accessibility and interoperability, particularly for rural health-care settings. Investing in technology infrastructure, providing adequate funding and support for rural providers to implement and maintain EHR systems, and ensuring standardized reporting mechanisms can all contribute to improving the timeliness and quality of care delivered to patients in these underserved areas. Such efforts can also help mitigate the administrative burdens that currently hinder optimal patient care in rural health-care settings.

Question. Do existing Federal quality and payment incentive programs under Medicare, like “Promoting Interoperability” under the Merit-based Incentive Payment System, enable up-to-date, consolidated longitudinal health records accessible without special effort?

Answer. Existing Federal quality and payment incentive programs under Medicare, such as the “Promoting Interoperability” initiative under the Merit-based Incentive Payment System (MIPS), do not necessarily enable up-to-date, consolidated longitudinal health records that are easily accessible without special effort.

The challenge lies in the practical implementation of these programs, especially for single-provider practices with limited technical expertise among their office staff. These practices often operate under tight budget constraints, making it difficult to allocate additional resources towards building and maintaining sophisticated health record systems that meet interoperability standards.

The costs associated with implementing and sustaining such systems can be prohibitive for small practices, preventing them from fully participating in Federal incentive programs aimed at promoting interoperability. As a result, these practices may struggle to achieve the level of data integration and accessibility necessary for seamless patient care coordination and quality reporting.

To address this issue, it’s crucial for Federal incentive programs to consider the unique challenges faced by small practices and provide adequate support, both in terms of funding and technical assistance. Simplifying the requirements, offering subsidies or grants specifically tailored to smaller providers, and facilitating partnerships with technology vendors or regional health information exchanges can all help bridge the gap and make longitudinal health records more accessible without imposing overwhelming financial burdens on these practices.

Question. With over \$40 billion spent and nearly 2 decades of effort put into implementing electronic health information technology, fax machines remain widely used for sharing health data in our health-care system.

Why is this the case and what challenges persist in accessing patients’ health information electronically?

Answer. The persistent reliance on fax machines can be attributed to several factors, and challenges in accessing patients’ health information electronically play a significant role in this dynamic.

One key reason for the continued use of fax machines is the financial and technological barriers faced by small providers. Many smaller practices lack the necessary funding and technical expertise to implement advanced Health Information Technology (HIT) solutions. The upfront investment required for transitioning to electronic data sharing platforms, such as secure messaging systems or interoperable electronic medical records (EMRs), can be substantial for these practices. As a result, fax machines remain a more manageable and familiar communication tool, especially when considering the limited resources available to small providers.

Additionally, the complexity and fragmentation of electronic health information systems pose ongoing challenges in accessing patients’ health information electronically. Interoperability issues between different EMR systems, varying data formats, and inconsistent data standards can hinder seamless data sharing and integration

across health-care entities. This lack of standardized processes and interoperable technologies contributes to the continued reliance on fax machines as a relatively simple and universally compatible means of exchanging health information.

Furthermore, regulatory and privacy concerns, such as HIPAA compliance requirements and concerns about data security breaches, also impact the adoption and utilization of electronic data sharing solutions. Small providers may be hesitant to embrace new technologies without assurances of data privacy and security, further contributing to the persistence of fax-based communication methods.

Addressing these challenges requires a concerted effort to support small providers in overcoming financial, technical, and regulatory barriers to adopting electronic health information technologies. This may involve providing financial incentives, offering technical assistance and training programs, promoting interoperability standards, and enhancing data security measures to foster a more seamless and secure electronic data sharing environment in health care.

PREPARED STATEMENT OF AMOL S. NAVATHE, M.D., PH.D., PROFESSOR OF HEALTH POLICY, MEDICINE, AND HEALTHCARE MANAGEMENT, PERELMAN SCHOOL OF MEDICINE AND THE WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA

To really help address the needs of patients with chronic diseases, we need information systems and teams that can help patients in between office visits, and we need financial incentives that reward providers for adopting them.

—Dr. Thomas Lee, M.D., M.Sc., Network President for Partners Healthcare System and Chief Executive Officer, Partners Community HealthCare, Inc.

Chairman Wyden, Ranking Member Crapo, and distinguished members of the committee, thank you for the opportunity to testify today. My name is Dr. Amol Navathe. I am a primary care-trained internal medicine physician and a Ph.D.-trained health economist. I would like to highlight why the Medicare program needs to better address chronic care for its beneficiaries and how changes to physician payment can support improvements. As a practicing physician, I have a front row seat in witnessing the challenges that Medicare beneficiaries face in receiving optimal care for chronic conditions.

Take for example, my patient Mr. L. He is a wonderful, elderly gentleman suffering from diabetes, heart failure, kidney disease, and a concern for kidney cancer. Most notably, he lives alone with no living spouse or children to help care for him. While I do my best to help Mr. L get his medications on time and make it to his specialist appointments, our fragmented system does not make it easy. Mr. L has to manage his chronic conditions on his own, spending up to an average of 2 hours a day coordinating his medications, traveling to appointments, and interacting with the health system.¹ He is an archetypal Medicare patient who would benefit from a more proactive and supportive model of care, ensuring that he gets his routine care to avoid long, avoidable, and expensive hospitalizations, like the one he had last month for acute kidney failure. In learning from Mr. L's situation, I would like to share three key points.

I. CHRONIC DISEASES MAY BE THE SINGLE MOST IMPORTANT CHALLENGE AFFECTING MEDICARE BENEFICIARIES AND THUS THE MEDICARE PROGRAM

The U.S. has the highest rate of individuals with multiple chronic conditions.² Some of the most common conditions include heart disease, cancer, dementia, diabetes, and chronic kidney disease. More than two-thirds (69 percent) of the Medicare population is diagnosed with two or more chronic conditions, with *one in seven* beneficiaries (15 percent) having six or more conditions.³ These 15 percent alone account

¹Jowsey T, Yen L, W PM. Time spent on health related activities associated with chronic illness: A scoping literature review. BMC Public Health. 2012 Dec 3;12:1044. doi: 10.1186/1471-2458-12-1044.

²Munira Z, Gunja, Evan D. Gumas, and Reginald D. Williams II, U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes (Commonwealth Fund, Jan. 2023). <https://doi.org/10.26099/8ejy-yc74>.

³Centers for Medicare and Medicaid Services. Medicare Multiple Chronic Conditions 2015 data. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/MCC_Main.html.

for \$92 billion in emergency visits, hospitalizations, and post-acute care, with their overall care resulting in over \$150 billion dollars of Medicare spend.⁴ Across the entire U.S. adult population, 27 percent are estimated to have multiple chronic conditions, costing the American health-care system more than \$1 trillion annually.^{5,6} When incorporating the costs associated with lost economic productivity, this number balloons to \$3.7 trillion.⁷ The overall financial impact is likely to increase moving forward, given projections related to an aging U.S. population.

This financial impact also affects patients directly. For example, patients with chronic disease have increased adverse financial outcomes compared with healthier patients.⁸ Of individuals with medical debt, those with 7 or more conditions owed an estimated \$1,252 compared with \$784 for those with no chronic diseases.⁹ Patients experiencing chronic diseases face additional difficulties, such as the inability to work due to symptoms, managing their disease, and other health implications.¹⁰ The experiences of beneficiaries living with chronic conditions, as well as the experiences of the clinicians caring for them, convey a compelling case for why the Medicare program must address the challenges of chronic disease care in a timely fashion.

II. DRAMATIC FRAGMENTATION IN CARE MAKES ADDRESSING CHRONIC DISEASE A BURDEN

One of the most important challenges in managing chronic conditions is the extremely fragmented nature of the U.S. health-care system. As an illustrative fact, over a third of Medicare beneficiaries (35 percent) received care from five or more physicians in 2019, a number likely to be higher among beneficiaries with chronic conditions.¹¹ That reflects not only a substantial number of physician visits, diagnostic tests, treatments, and prescriptions that beneficiaries have to keep track of, but also the many opportunities for care details to slip through the cracks. For a primary care physician (PCP) to effectively coordinate care for a single medical condition it can require upwards of 50 interactions in a 3-month period (through various modes of communication) between patient, primary care physician, and other physicians.¹² Moreover, there has been a substantial increase in the total number of other clinicians a PCP's Medicare panel of patients saw between 2000 and 2019, from a median of 52 to 1 of 95 physicians.¹³ While having multiple physicians can tailor treatment to the needs of a patient's condition, it can also increase the likelihood of medical errors, redundant visits, preventable hospitalizations, and sub-standard care due to incomplete communication and differing treatment strategies. Each individual interaction adds complexity. This demonstrates the challenging role of a PCP, highlighting a structural complexity in managing care for those with

⁴Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD. 2012. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf>.

⁵Boersma P, Black LI, Ward BW. Prevalence of multiple chronic conditions among U.S. adults, 2018. *Prev Chronic Dis*. 2020;17:E106.

⁶Waters H, Graf M, editors. The costs of chronic disease in the U.S. 1st ed. Milken Institute; 2018. https://milkeninstitute.org/sites/default/files/reports-pdf/ChronicDiseases-HighRes-FINAL_2.pdf.

⁷*Ibid.*

⁸Becker NV, Scott JW, Moniz MH, Carlton EF, Ayanian JZ. Association of Chronic Disease With Patient Financial Outcomes Among Commercially Insured Adults. *JAMA Intern Med*. 2022;182(10):1044–1051. doi:10.1001/jamainternmed.2022.3687.

⁹Slomski A. Chronic Disease Burden and Financial Problems Are Intertwined. *JAMA*. 2022;328(13):1288–1289. doi:10.1001/jama.2022.15440.

¹⁰Boersema HJ, Hoekstra T, Abma F, Brouwer S. Inability to Work Fulltime, Prevalence and Associated Factors Among Applicants for Work Disability Benefit. *J Occup Rehabil*. 2021 Dec;31(4):796–806. doi: 10.1007/s10926-021-09966-7. Epub 2021 Mar 12. PMID: 33710457; PMCID: PMC8558289.

¹¹Barnett ML, Bitton A, Souza J, Landon BE. Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000 to 2019. *Ann Intern Med*. 2021 Dec; 174(12):1658–1665. doi: 10.7326/M21-1523. Epub 2021 Nov 2. Erratum in: *Ann Intern Med*. 2022 Oct;175(10):1492. PMID: 34724406; PMCID: PMC8688292.

¹²Press MJ. Instant Replay—A Quarterback's View of Care Coordination. *New England Journal of Medicine*. 2014;371:489–491. doi: 10.1056/NEJMp1406033.

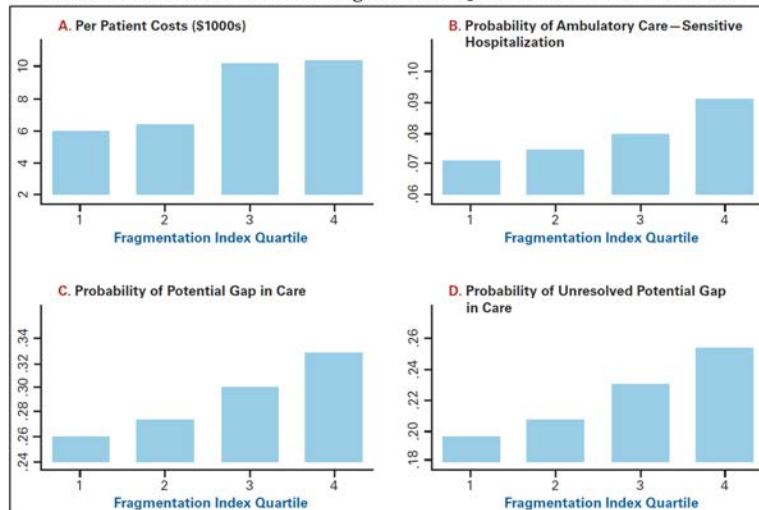
¹³Barnett ML, Bitton A, Souza J, Landon BE. Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000 to 2019. *Ann Intern Med*. 2021 Dec; 174(12):1658–1665. doi: 10.7326/M21-1523. Epub 2021 Nov 2. Erratum in: *Ann Intern Med*. 2022 Oct;175(10):1492. PMID: 34724406; PMCID: PMC8688292.

chronic conditions amidst a backdrop of increasing specialization and resulting fragmentation.

A study involving patients with diabetes and chronic kidney disease revealed significant repercussions of fragmented care on emergency department (ED) utilization. Every 0.1-unit increase in the fragmentation of care (encompassing number of different providers visited, the proportion of attended visits to each of those providers, and the total number of visits) was associated with a 15-percent increase in the number of ED visits (incidence rate ratio, 1.15; 95 percent CI, 1.09–1.21).¹⁴ Another study, specifically focused on Medicare beneficiaries with chronic conditions, similarly reported that incremental and heightened fragmentation significantly increased the risk of both ED visits and hospital admissions (by 14 percent for each; adjusted $P < .05$ for each comparison).¹⁵

Beneficiaries with chronic conditions face the burden of fragmentation across the care continuum. Among patients with 5 or more chronic conditions, patients experiencing the highest degree of care fragmentation underwent roughly twice as many radiology and other diagnostic procedures as those experiencing the lowest level of fragmentation, translating to an additional 284 tests per 100 patients, or an increase of 110 percent (adjusted $p < 0.01$).¹⁶ A study from the Harvard Chan School of Public Health assigned patients a fragmentation index based on their PCP's practice style, measured by the number of other physicians seen by their PCP's panel. The authors found increased departures from clinical best practice, higher rates of preventable hospitalizations, and higher health-care spending in the highest fragmentation quartile versus the lowest fragmentation quartile (\$10,396 versus \$5,854, $p < 0.001$) (Exhibit 1).¹⁷

Exhibit 1. Association Between Fragmentation Quartile and Patient Outcomes.



Notes: Higher fragmentation of care for a PCP's panel was associated with poorer patient outcomes.

Source: Frandsen, BR., et al. "Care fragmentation, quality, and costs among chronically ill patients." *Am J Manag Care* 21.5 (2015): 355–362.

¹⁴Liu CW, Einstadter D, and Cebul RD. "Care fragmentation and emergency department use among complex patients with diabetes." *The American journal of managed care* 16.6 (2010): 413–420.

¹⁵Kern LM, et al. "Fragmented ambulatory care and subsequent healthcare utilization among Medicare beneficiaries." *Am J Manag Care* 24.9 (2018): e278–e284.

¹⁶Kern LM, et al. "Healthcare fragmentation and the frequency of radiology and other diagnostic tests: A cross-sectional study." *Journal of general internal medicine* 32 (2017): 175–181.

¹⁷Frandsen BR, et al. "Care fragmentation, quality, and costs among chronically ill patients." *Am J Manag Care* 21.5 (2015): 355–362.

III. THE AMERICAN CARE SYSTEM PRIORITIZES PRODUCING MORE HEALTH CARE, RATHER THAN PRODUCING MORE HEALTH

The prevailing fee-for-service (FFS) reimbursement system is a key driver in producing such a fragmented system. FFS reimbursement pays physicians and other health-care providers based on volume of activities, creating a system that incentivizes each clinician to focus on increasing the number of visits and procedures.¹⁸ The complex task of coordinating care, especially for beneficiaries with chronic conditions, is not directly reimbursed and therefore gets overlooked.¹⁹

With good intentions, the Centers for Medicare and Medicaid Services (CMS) have tried to fill this gap by adding more billing codes in an attempt to more comprehensively tie payment to effort. Unfortunately, it is a fraught effort to reduce the important work of physicians and other health-care providers to a list of codes. This has resulted in an administratively burdensome system of “ticky tack” codes that get underused because the cost of submitting the bill exceeds the payment doctors receive. I sometimes call this “death by a thousand codes.” For example, the billing cost for a visit has been estimated to be \$20.49,²⁰ exceeding CMS’s initially proposed \$15 FFS payment for a phone call or other “virtual check-in” visit. This places PCPs in a difficult situation: shoulder substantial administrative burden to deliver and bill for these services, deliver but do not bill for these services, or do not provide these services at all. Either of the first two options is financially perverse and the third is clinically perverse. Consequently, the core issue of fragmentation does not get systematically addressed.²¹

Adding billing code upon billing code increases administrative complexity while failing to appropriately pay primary care practices for all the services they provide off of the fee schedule, an estimated 25 percent of their activities.²² Studies show that 60 percent of primary care visits deliver services that are not reportable in CPT (Current Procedural Terminology) codes.²³ Examples of these services include checking insurance coverage for patients, addressing social determinants of health during visits, and discussing medication options. All of these are critical for effective delivery of medical care, but providers are not compensated for them.

What can we do to fix this? Despite the challenge facing beneficiaries, doctors, and policymakers, there are some potential options we can consider.

Any effort to improve chronic disease care will require a change in the way health care is delivered, a different “model of care” to address fragmentation. It will require physician groups to be able to invest in new capabilities; use technologies like telehealth when they are safe, efficient, and effective; and expand the role of staff practices, including care coordinators and case managers. For example, there is a growing workforce of nurse practitioners in primary care who help bolster access and improve care coordination, demonstrating successful care model shifts. A crucial element to enable a new model of care, however, is substantial change to physician payment. Simply adding more dollars to the current system is unlikely to address the chronic care crisis in Medicare. Instead, thoughtful care redesign is needed.

A natural place to start is to invest more in primary care, empowering PCPs to act as the “quarterback” or “point guard” of a patient’s care team. Robust primary care has consistently demonstrated an improvement in population health and reduction in health disparities.²⁴ Despite this, the United States systematically underinvests in primary care. Expenditure on primary care in the U.S. has

¹⁸ Zyzanski SJ, Stange KC, Langa D, Flocke SA. Trade-Offs in High-Volume Primary Care Practice. *J Fam Pract.* 1998;46:397–402.

¹⁹ Young RA, Burge S, Kumar KA, Wilson J. The Full Scope of Family Physicians’ Work Is Not Reflected by Current Procedural Terminology Codes. *J Am Board Fam Med.* 2017 Nov–Dec;30(6):724–732. doi: 10.3122/jabfm.2017.06.170155.

²⁰ Tseng P, Kaplan RS, Richman BD, Shah MA, Schulman KA. Administrative costs associated with physician billing and insurance-related activities at an academic health care system. *JAMA.* 2018;319(7):691–697. doi:10.1001/jama.2017.19148.

²¹ Berenson R, Shartz A. The Mismatch of Telehealth and Fee-for-Service Payment. *JAMA Health Forum.* 2020;1(10):e201183. doi:10.1001/jamahealthforum.2020.1183.

²² Young RA, Burge S, Kumar KA, Wilson J. The Full Scope of Family Physicians’ Work Is Not Reflected by Current Procedural Terminology Codes. *J Am Board Fam Med.* 2017 Nov–Dec;30(6):724–732. doi: 10.3122/jabfm.2017.06.170155.

²³ *Ibid.*

²⁴ Jabbarpour Y, Petterson S, Jetty A, Byun H, Robert Graham Center. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. *Milbank Quarterly.* 2023 Feb. https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf.

declined over the past decade, ranging from 6.2 percent in 2013 to 4.6 percent in 2020 across all insurance types. Medicare spends an estimated 4 percent of its total spending on primary care,^{25, 26, 27} about \$15 billion per year, which is half that of many other developed countries.²⁸ In contrast, we spend more on inpatient care and hospitalizations than other nations. Within the U.S., primary care is systematically underinvested relative to other specialties,^{29, 30} despite the fact that PCPs play the central role in a patient's health and face the cognitively and logistically complex task of care coordination and integration. Procedural specialties are compensated significantly more than primary care and other office-based specialties.^{31, 32, 33} Changing fee schedule weights alone will not fix this; studies demonstrated that a recent upweighting of reimbursement for office visits led to only a 2-percent decrease in the Medicare payment gap between primary care and specialty physicians (from a gap of \$40,259.80 to one of \$39,434.70).³⁴

Beyond mobilizing more dollars into primary care, we need to enable PCPs to invest in new capabilities and grant them more flexibility. One potential path would be to provide PCPs with consistent per-beneficiary per-month (PBPM) payments in addition to certain fee-for-service payments.³⁵ These PBPM payments would be designed to cover the estimated 25 percent of PCP activities that are not currently captured in the Medicare Physician Fee Schedule, such as care coordination, communication with other providers, addressing social determinants of health, and improving patient and caregiver health literacy. Consequently, a benefit of such an approach is that it would unshackle PCPs from a system that tries to capture every activity across thousands of codes, since the litany of codes would no longer be necessary (since the associated clinical activities would be included in the monthly payment). This would also balance the goals of preserving access through FFS payments while enabling PCPs to practice more patient-centered, rather than visit-centered, care. The PBPM payments would allow PCPs to invest in sustainable practice infrastructure transformation such as hiring case managers and care coordinators or integrating technology and team-based care. Such care model redesign is of particular importance for improving the health of patients with multiple chronic conditions while reducing wasteful administrative complexity.

Hybrid primary care payments cannot be implemented at scale without congressional action. The Centers for Medicare and Medicaid Services (CMS) have conducted several demonstration projects implementing hybrid payments (e.g., Comprehensive Primary Care Plus). It also has the authority to—and should—implement hybrid payments in the Medicare Shared Savings Program (MSSP),³⁶ the

²⁵ New “Scorecard” Finds Primary Care Funding and Physician Workforce Are Shrinking. AA of Family Physicians. February 24, 2023. <https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/primary-care-scorecard.html>.

²⁶ Jabbarpour Y, Petterson S, Jetty A, Byun H, Robert Graham Center. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. *Milbank Quarterly*. 2023 Feb. https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf.

²⁷ Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Intern Med*. 2019 Jul 1;179(7):977–980. doi: 10.1001/jamainternmed.2018.8747.

²⁸ OECD Country Health Profiles, 2023. <https://www.oecd.org/els/health-systems/primary-care.htm>.

²⁹ Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Intern Med*. 2019;179(7):977–980. doi:10.1001/jamainternmed.2018.8747v.

³⁰ Zuckerman S, Merrell K, Berenson RA, Cafarella Lallemand N, and Sunshine J. 2015. Realign Physician Payment Incentives in Medicare to Achieve Payment Equity Among Specialties, Expand the Supply of Primary Care Physicians, and Improve the Value of Care for Beneficiaries. Washington, DC: Urban Institute, Social & Scientific Systems Inc.

³¹ Hsiao WC, Braun P, Yntema D, Becker ER. Estimating Physicians' Work for a Resource-Based Relative-Value Scale. *N Engl J Med*. 1988; 319:835–41.

³² Katz S, Melmed G. How Relative Value Units Undervalue the Cognitive Physician Visit: A Focus on Inflammatory Bowel Disease. *Gastroenterol Hepatol (NY)*. 2016 Apr;12(4):240–4.

³³ Bodenheimer T, Berenson RA, Rudolf P. The Primary Care-Specialty Income Gap: Why It Matters. *Ann Intern Med*. 2007 Feb 20;146(4):301–6. doi: 10.7326/0003-4819-146-4-200702200-00011.

³⁴ Neprash HT, Golberstein E, Ganguli I, Cherner ME. Association of Evaluation and Management Payment Policy Changes with Medicare Payment to Physicians by Specialty. *JAMA*. 2023;329(8):662–669. doi:10.1001/jama.2023.0879.

³⁵ Berenson RA, Shartz A, Pham HH. Beyond demonstrations: Implementing a primary care hybrid payment model in Medicare. *Health Affairs Scholar*. 2023 Aug;1(2):qxad024.

³⁶ Commonwealth Fund. Response to Request for Information on HHS Initiative to Strengthen Primary Health Care from the Office of the Assistant Secretary for Health, Department of

largest accountable care program in Medicare. The ACO Primary Care Flex Model is a step in that direction.³⁷ However, moving past demonstrations to impact Medicare beneficiaries nationwide will require Congressional action to grant CMS the appropriate authority.

The evidence for hybrid payments is promising. Blue Cross Blue Shield of Hawaii, or Hawaii Medical Services Association (HMSA), has conducted what is perhaps the most rigorous test of hybrid payments for primary care to date in its Population-based Payments for Primary Care (3PC) model. The 3PC model is a hybrid model that shifted the majority of payments to PCPs to a risk-adjusted per-member per-month payment, while continuing to pay some services as FFS.

The transformative elements of HMSA's 3PC model relate to its large market share; across its commercial, Medicare Advantage, and Managed Medicaid lines of business, HMSA retains large shares of patients and revenue for most of its PCPs. The model led to marked improvements in quality, greater use of telehealth that predated the COVID-19 pandemic, and fewer low-value imaging tests.³⁸ This included increased rates of cost-effective prevention such as blood pressure control among patients with diabetes (2.7-percent differential increase), as well as greater cost-saving care such as a 5.5-percent differential increase in advance care planning (Exhibit 2).³⁹ In fact, unlike other states where primary care practice finances were massively disrupted by the COVID-19 pandemic, practices in Hawaii were protected financially, as PCPs were well-equipped to care for patients effectively in a remote fashion because they had already made such infrastructure investments. The experience and transformative successes in Hawaii underscore the stability and ability to invest that hybrid payments can impart to primary care practices.

Notes: Significant differential improvement in blood pressure control among patients with diabetes and advance care planning in hybrid payment group versus control group. Source: Navathe AS et al. Association Between the Implementation of a Population-Based Primary Care Payment System and Achievement on Quality Measures in Hawaii. JAMA. 2019 Jul 2;322(1):57–68.

Beyond private payers in Hawaii, CMS has been testing “advanced primary care models” at a national level using hybrid payments in Medicare for over a decade with promising “leading indicator” results. These models led to fewer emergency department visits and hospitalizations, while producing modest gains in chronic disease management and prevention. In Comprehensive Primary Care (CPC, 2012–2016), hospitalizations and emergency department visits increased by 2 percent less among participating practices.⁴⁰ This represented a statistically significant relative reduction of 8,150 hospitalizations and 15,472 outpatient emergency department (ED) visits over the 4 years of the program. Importantly, practices with greater access to resources or more experience with care delivery transformation were more likely to reduce growth in expenditures (~2 percent). This highlights the importance of providing practices with resources for successful and sustainable transformation.

Health and Human Services. https://www.commonwealthfund.org/sites/default/files/2022-08/TO%20ATTACH%20AS%20DOWNLOAD_Commonwealth%20Fund_OASH%20Primary%20Care%20RFI_7.29.22.pdf.

³⁷ <https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model>.

³⁸ Dinh CT, Linn KA, Isidro U, Emanuel EJ, Volpp KG, Bond AM, Caldarella K, Troxel AB, Zhu J, Yang L, Matloubieh SE, Drye E, Bernheim S, Lee EO, Mugiishi M, Endo KT, Yoshimoto J, Yuen I, Okamura S, Tom J, Navathe AS. Changes in Outpatient Imaging Utilization and Spending Under a New Population-Based Primary Care Payment Model. J Am Coll Radiology. 2020 Jan;17(1 Pt B):101–109. doi: 10.1016/j.jacr.2019.08.013. PMID: 31918865.

³⁹ Navathe AS, Emanuel EJ, Bond A, Linn K, Caldarella K, Troxel A, Zhu J, Yang L, Matloubieh SE, Drye E, Bernheim S, Lee EO, Mugiishi M, Endo KT, Yoshimoto J, Yuen I, Okamura S, Stollar M, Tom J, Gold M, Volpp KG. Association Between the Implementation of a Population-Based Primary Care Payment System and Achievement on Quality Measures in Hawaii. JAMA. 2019 Jul 2;322(1):57–68. doi: 10.1001/jama.2019.8113.

⁴⁰ Evaluation of the Comprehensive Primary Care Initiative: Fourth Evaluation Report. Mathematica. 2018 May. <https://downloads.cms.gov/files/cmml/CPC-initiative-fourth-annual-report.pdf>.

Exhibit 2. Changes in Quality Measures in the Population-Based Payments for Primary Care—Hawaii Medical Services Association.

Quality	3PC, %			Non-3PC, %			Unadjusted Differential Change, Percentage Points	P Value	Adjusted	
	2012-2015	2016	Difference	2012-2015	2016	Difference			Differential Change, Percentage Points (95% CI)	P Value ^a
No. of unique patients	74 371	58 270	NA	207 159	140 772	NA	NA	NA	NA	NA
No. of PCPs	107	107	NA	312	312	NA	NA	NA	NA	NA
Composite measure score (n = 284 544) ^b	76.4	84.6	8.2	76.8	83.4	6.7	1.5	<.001	2.3 (2.1 to 2.6)	<.001
Advance care planning (n = 42 102)	40.9	75.7	34.8	37.0	67.2	30.1	4.7	<.001	5.5 (4.3 to 6.7) ^c	<.001
Body mass index assessment (n = 245 415)	72.1	88.1	16.0	74.9	85.5	10.6	5.4	<.001	4.5 (4.1 to 5.0) ^d	<.001
Breast cancer screening (n = 62 230)	82.8	85.7	2.9	84.7	86.7	2.0	0.9	.03	0.9 (0.2 to 1.5)	.07
Cervical cancer screening (n = 74 426)	82.2	82.2	0.0	81.1	82.0	0.9	-0.9	.02	-1.1 (-1.8 to -0.5) ^e	.01
Diabetes care										
Blood pressure control (<140/90 mm Hg) (n = 31 683)	63.7	87.2	23.5	64.2	84.6	20.5	3.0	<.001	2.7 (1.6 to 3.8) ^f	<.001
Eye examination (n = 32 072)	74.8	79.3	4.6	73.8	76.8	3.0	1.6	.02	1.4 (0.2 to 2.6)	.14
HbA _{1c} in control (≤9.0%) (n = 29 581)	77.1	84.9	7.8	76.6	84.4	7.8	0.1	.92	0.0 (-1.1 to 1.1) ^g	>.99
Medical attention for nephropathy (n = 32 072)	92.4	96.0	3.6	91.1	95.3	4.2	-0.6	.13	-0.5 (-1.2 to 0.2)	.73
Childhood immunization status (n = 12 636)	87.2	94.2	6.9	84.7	89.0	4.3	2.6	.45	0.31 (-4.8 to 5.4) ^h	>.99
Colorectal cancer screening (n = 106 150)	79.4	83.3	3.8	77.8	81.6	3.7	0.2	.62	0.2 (-0.3 to 0.7)	>.99
Immunizations for adolescents (n = 16 380)	73.2	84.3	11.1	71.6	78.5	6.9	4.1	.07	1.3 (-2.5 to 5.2) ⁱ	>.99
Well-child visits										
First 15 mo of life (n = 9757)	92.8	NA	NA	88.8	NA	NA	NA	NA	NA ^j	NA
Third, fourth, fifth, and sixth years of life (n = 29 743)	90.7	91.4	0.8	87.9	90.2	2.3	-1.6	.05	-2.9 (-4.4 to -1.5) ^k	<.001
Abbreviations: HbA _{1c} , glycated hemoglobin; NA, not applicable; PCP, primary care practitioner.										
^a Reported P values are adjusted for Holm-Bonferroni correction except for the primary outcome of the Composite Measure Score.							^d Data only available for 2014-2016.			
^b The composite measure score indicates the probability of achieving a quality measure for which a patient was eligible in a given year, with a range between 0% and 100% (with higher percentages indicating higher quality achievement). The score was computed by taking the mean of the number of measures achieved divided by the number of eligible measures by patient, weighted by a patient's number of eligible measures. It included the 13 pooled individual Healthcare Effectiveness Data and Information Set-based quality measures in this table that were also incentivized in the prior pay-for-quality program and thus had preintervention and postintervention data available. An improvement in quality would require the mean probability of achievement to increase across all eligible measures, not just a single measure.							^e Data only available for 2013-2016.			
^c Data only available for 2014-2016.							^f Data only available for 2013-2016.			
							^g Data only available for 2014-2016.			
							^h Status only available for 2013-2016.			
							ⁱ Data only available for 2013-2016.			
							^j Data only available for 2013-2015 and therefore cannot be represented in this data set.			
							^k Data only available in 2013-2016. Of the pediatric members who did not meet the well-child visit measure, 72.8% in the 3PC group had at least 1 PCP visit, with a mean of 2.4 visits, and 73.2% in the non-3PC group had at least 1 PCP visit, with a mean of 2.5 visits. This likely suggests that the differences in access or follow-up were quite small between the groups.			

Comprehensive Primary Care Plus (CPC+, 2017–2021) similarly saw a 2-percent reduction in ED visits that emerged early and persisted across the 5 program years.⁴¹ A 2-percent reduction in hospitalizations emerged in program years 3 and 4 and was driven by reductions in medical admissions, suggesting that these admissions were prevented by improved outpatient care. Furthermore, over the 5 years of the program, the percentages of beneficiaries who received all recommended services for diabetes increased by about 1 percentage point and of females who received breast cancer screening increased by about 1 percentage point. CPC+ had more favorable effects among concurrent MSSP participants, again suggesting that practices can build experience with care transformation with time and proper investment. These demonstrations suggest that transforming primary care payment can have important implications for beneficiaries with multiple chronic conditions, such as decreasing emergency department visits and hospitalizations while improving the delivery of robust well-integrated and well-coordinated primary care.

Another approach would be to continue expansion of alternative payment models (APMs), which increase accountability for cost and quality outcomes onto providers, shifting provider focus to value. This will require

⁴¹ Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Evaluation Report. Mathematica. 2023 Dec. <https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report>.

continued support for the CMS Innovation Center. There is some evidence that APMs can improve care for beneficiaries with both high and low burdens of chronic disease. A great example has been the Accountable Care Organization (ACO) model.

The ability of ACOs to improve quality measures and drive savings is particularly evident through their performance in the MSSP. Notably, physician-led ACOs are more successful than other ACOs. An evaluation studying differential changes in annual per-beneficiary utilization and total Medicare spending found that physician-led ACOs demonstrated significant improvements and growing savings for Medicare over a 3-year period in the MSSP.⁴² Among the physician-group led ACOs, the study reported statistically significant reductions (differential change) for annual per-beneficiary any-cause hospitalization (-0.008), ED visits (-0.018), and post-acute facility stays. In contrast, hospital-led ACOs showed statistically significant reductions in ED visits (-0.009) only. Per-beneficiary spending reductions were significant in both ACO types, but larger for physician-led ACOs.⁴³ The spending reductions observed in ACOs led by physicians resulted in a net savings of \$256.4 million for Medicare in 2015, while the corresponding spending reductions in ACOs integrated with hospitals were offset by bonus payments.⁴⁷ The integration facilitated by ACOs, particularly those led by physicians, can be important among beneficiaries with chronic conditions, as fragmented management of these conditions is known to drive a significant portion of overall Medicare spending.

Another evaluation analyzed outcomes of ACOs entering MSSP in 2012 through 2014, stratifying beneficiaries as either low-risk or high-risk based on the number of chronic conditions. The authors identified improvements in quality measures such as a reduction in annual hospitalizations, with statistically significant reductions among the high-risk patients in 2012 only and reductions for low-risk patients in both 2012 and 2013. Among hospitalizations for ambulatory care-sensitive conditions in the 2012 cohort, participation in MSSP was linked with a decrease in the proportion of patients hospitalized for chronic obstructive pulmonary disease or asthma (-0.05 percentage points, or 4.8 percent of the precontract mean). However, there were significant increases in the proportion hospitalized for congestive heart failure (0.05 percentage points, or 3.6 percent) and cardiovascular disease or diabetes (0.07 percentage points, or 3.5 percent).⁴⁴ High-risk patients experienced a substantially greater absolute decrease in spending ($-\$686$ versus $-\$207$), while relative reductions were similar between the two groups (-3.0 percent versus -2.9 percent). The notable decrease in spending and admissions observed in the 2013 cohort predominantly stemmed from reductions among patients classified as low-risk.

In another evaluation of nearly a dozen ACOs, PCP clinical staffing type played a pivotal role in influencing financial gains within ACOs.^{45,46} An increase of one primary care visit per beneficiary-year administered by PCPs resulted in significant average gains of \$49.65, \$40.84, and \$27.31 in earned shared savings per beneficiary for hybrid, hospital-led, and physician-led ACOs, respectively ($p < 0.001$). These findings underscore the impact of primary care providers within the ACO framework, especially for managing chronic conditions.

To date, the MSSP has saved CMS \$1.8 billion by its own estimates.⁴⁷ When advanced primary care models have overlapped with ACOs, the synergies have yielded even larger savings, up to 3 percent lower Medicare spending per beneficiary or about \$300 in annual savings per beneficiary.⁴⁸ This provides supportive evidence for CMS using its existing authority to implement hybrid primary care payment in MSSP.

⁴² McWilliams JM, et al. Medicare Spending After 3 Years of the Medicare Shared Savings Program. *New England Journal of Medicine* 379.12 (2018): 1139–1149.

⁴³ *Ibid.*

⁴⁴ McWilliams, JM, Chernew ME, and Landon BE. Medicare ACO program savings not tied to preventable hospitalizations or concentrated among high-risk patients. *Health Affairs* 36.12 (2017): 2085–2093.

⁴⁵ Lemaire N and Singer SJ. Do Independent Physician-Led ACOs Have a Future? *NEJM Catalyst* 4.1 (2018).

⁴⁶ Coyne J, et al. Financial Performance of Accountable Care Organizations: A 5-Year National Empirical Analysis. *Journal of Healthcare Management* 69.1 (2024): 74–86.

⁴⁷ Medicare Shared Savings Program Saves Medicare More Than \$1.8 Billion in 2022 and Continues to Deliver High-quality Care. CMS. 2023 Aug 24. <https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high>.

⁴⁸ Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Evaluation Report. Mathematica. 2023 Dec. <https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report>.

ACOs are an exemplar of the positive shifts in care that APMs can create for Medicare beneficiaries. Other APMs have also been successful in changing practice patterns toward greater quality and cost-efficiency. However, we should also note that most, if not all, APMs still rely on the Medicare Physician Fee Schedule. This can create complexities and conflicts in the financial incentives for many physicians.

This leads me to point out that CMS needs additional tools to manage the FFS program more effectively. The FFS system is only getting more complicated as new technologies and drugs emerge and as clinical care becomes increasingly specialized and sub-specialized.⁴⁹ There are many factors to consider in improving physician payment, and no single entity has all of the required expertise. Payment changes will require multidisciplinary experts to provide input to CMS who could be convened as a panel.⁵⁰ Ultimately, CMS needs the ability to catalyze a new care model and that will require adapting the fee schedule to accommodate approaches like a PBPM payment.

A recent effort to address the undervaluation of primary and outpatient care led to evaluation and management (office visit) weights being increased in 2021 by up to 20 percent. This also resulted in a corresponding decrease in weights to other services to maintain budget neutrality. However, this was a refinement in the current payment structure rather than enablement of a shift. Looking forward, it will be important to give CMS the ability to scale payment approaches that support better care for beneficiaries with chronic diseases.

Telehealth represents one example of an opportunity for improved care management of patients with multiple chronic conditions. When so much of patients' time is spent traveling to and from office visits, capitalizing on technological advancements could offer one means by which this burden can be reduced, and health outcomes can be improved. For example, one care coordination approach using telehealth for chronically ill Medicare beneficiaries demonstrated significant savings of approximately 7.7–13.3 percent (\$312–\$542) per person per quarter.⁵¹ Reforms to primary care payment, which enable investment in practice-transforming programs such as telehealth in this study, can improve the care of beneficiaries with multiple chronic conditions. While telehealth is a great potential area of opportunity, implications of accessibility and feasibility must be taken into consideration given the nuances of supporting an aging population. Furthermore, telehealth, like other services, may be susceptible to overuse if paid for in the usual FFS structure.

Primary care practices can also improve the health of patients with multiple chronic conditions by hiring community health workers (CHWs). A CHW is a “front-line public health worker who is a trusted member of the community served, which enables the worker to serve as a liaison between health/social services and the community to facilitate access and improve the quality and cultural competence of service delivery.”⁵² CHW visits can help patients improve their self-efficacy and health literacy in managing multiple chronic conditions. Randomized controlled trials of CHWs have demonstrated improvements in hospital admissions, hospital length of stay, chronic disease control, and mental health for patients with chronic conditions.⁵³ These programs have also improved measurable health outcomes such as hemoglobin A1C, Body Mass Index, cigarettes per day, and blood pressure.⁵⁴ In Medicaid, CHWs have been estimated to return an annual \$2.47 for every dollar in-

⁴⁹ Hunter K, Kendall D, Ahmadi L. “The Case Against Fee-for Service Health Care,” September 9, 2021. <https://thirdway.imgix.net/pdfs/the-case-against-fee-for-service-health-care.pdf>.

⁵⁰ National Academy of Medicine; Finkelman EM, McGinnis JM, McClellan MB, et al., editors. *Vital Directions for Health & Health Care: An Initiative of the National Academy of Medicine*. Washington (DC): National Academies Press (U.S.); 2017. 9, Payment Reform for Better Value and Medical Innovation. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK595162/>.

⁵¹ Baker LC, Johnson SJ, Macaulay D, Birnbaum H. Integrated telehealth and care management program for Medicare beneficiaries with chronic disease linked to savings. *Health Aff (Millwood)*. 2011 Sep;30(9):1689–97. doi: 10.1377/hlthaff.2011.0216. PMID: 21900660.

⁵² “Community Health Workers.” American Public Health Association. <https://www.apha.org/apha-communities/member-sections/community-health-workers/>.

⁵³ Kangovi S, Mitra N, Grande D, et al. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. *JAMA Intern Med*. 2014;174(4):535–543. doi:10.1001/jamainternmed.2013.14327.

⁵⁴ Kangovi S, Mitra N, Grande D, Huo H, Smith RA, Long JA. Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial. *Am J Public Health*. 2017 Oct;107(10):1660–1667. doi: 10.2105/AJPH.2017.303985.

vested.⁵⁵ Hospital-based health systems across the country have begun to incorporate CHW programs, such as the IMPaCT (Individualized Management for Patient-Centered Targets) program at the University of Pennsylvania. Reforming primary care payment can enable practices to invest in CHW programs, one such innovation in care management to improve the care of patients with chronic disease.

Acting now is paramount to improve the landscape of chronic condition care management and payment. Unlike in Medicare Advantage, where we have seen substantial innovation to meet beneficiary needs on a near real-time basis, traditional Medicare requires Congressional action to stay up to date. It is imperative to give CMS the tools and authorities it requires to address chronic diseases among Medicare beneficiaries. Thank you for the opportunity to share my testimony with you today.

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QUESTIONS SUBMITTED FOR THE RECORD TO AMOL S. NAVATHE, M.D., PH.D.

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. Advanced Alternative Payment Models (AAPMs) hold significant promise as a means of driving improved value while ensuring appropriate and targeted stewardship of Federal Medicare dollars for both beneficiaries and taxpayers.

What specific steps should Congress or CMS take in order to improve uptake of these models, including for specialties with low participation rates?

Answer. Alternative payment models (APMs) serve as a form of value-based payment (VBP) that continues to demonstrate promise as a potential avenue forward for the American health-care system, particularly within care model delivery and financing. Over the past few decades, APMs have evolved as a key model to drive value while saving Federal dollars, with programs using two-sided risk creating the greatest impact.¹ While there have been concerns and challenges throughout the development of various attempts testing APMs implementation, the two that have shown the most promise are those that are population-based and episode-based.² The transition to value-based systems requires substantial time, research, and effort to best determine methodology; as such, seeing additional potential within both care

⁵⁵ Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment. *Health Aff (Millwood)*. 2020 Feb;39(2):207–213. doi: 10.1377/hlthaff.2019.00981.

¹ Final Rule Creates Pathways to Success for the Medicare Shared Savings Program. [Press release]. U.S. Centers for Medicare and Medicaid Services. Retrieved from <https://www.cms.gov/newsroom/fact-sheets/final-rule-creates-pathways-success-medicare-shared-savings-program>.

² Liao JM, Navathe AS, Werner RM. (2020). The Impact of Medicare's Alternative Payment Models on the Value of Care. *Annual Review of Public Health*, 41(1), 551–565. doi:10.1146/annurev-publhealth-040119-094327.

transformation and improved value in the form of savings will support further success.³

Advanced Alternative Payment Models (AAPMs) are models that are exemplary and can demonstrate most clearly the potential ability for these programs to be spread more widely. If CMS dedicates additional resources to encourage the uptake of these models, particularly in areas where low participation has been observed, further development is likely for such models in diverse sectors and climates.

Along with my peers at Leonard Davis Institute, we developed a suggested road-map for CMS to bolster efforts needed to evolve VBP systems, including APMs and AAPMs, suggesting the following:

- I. CMS must articulate a clear vision for the future of value-based payment.
- II. CMS must dramatically simplify the current value-based payment landscape and engage late-adopting providers.
- III. For health systems already participating in value-based payment, CMS must accelerate the movement from upside-only shared savings to risk-bearing, population-based alternative payment models while curtailing the ability of providers to opt out of value-based payment altogether.
- IV. CMS must not only pull providers toward Advanced Alternative Payment Models, but also structure incentives to push providers away from fee-for-service payment.
- V. Achieving health equity must be a central feature and goal of value-based payment.⁴

These suggestions still hold true, with an evident need for concerted effort and improved coordination across model design to further the potential ability for continued success.

Additional key lessons building upon that we propose for improving current systems in place include modification of design flaws in existing programs and how to address implementation challenges to encourage further participation in CMS's VBP programs.

Regarding design flaws, we review the following three as most problematic:⁵

1. Many VBP incentive designs require participants to forgo revenue for the opportunity to earn just a fraction of it back as shared savings. To address the issue of forgone revenue, VBP designs must target wasteful or inefficient spending outside the intended participant.
2. Many VBP models are vulnerable to "ghost savings," savings that occur when calculated on a risk-adjusted basis due to more intense coding but that are not present on a nominal (raw or unadjusted) basis.⁶ To address the issue of ghost savings, payers should require "real savings" to earn shared savings.
3. Most VBP experimental models are voluntary. To address the issues of voluntariness, the presumption for every new VBP model should be mandatory participation. In cases where mandatory enrollment is not feasible, building on regionalized demonstrations such as Medicare's Comprehensive Primary Care Plus model, voluntary models should be deployed in reasonably small geographic areas using randomization to offer participation in the model, preserving the ability to examine population-level effects.

To encourage further participation in VBP programs tailored to difficulty within implementation, we review the following areas and propose potential solutions for each: (1) consolidation and use of management service organizations; (2) paucity of

³McWilliams JM, Hatfield LA, Landon BE, Hamed P, Chernew ME. (2018). Medicare Spending after 3 Years of the Medicare Shared Savings Program. *N Engl J Med*, 379(12), 1139–1149. doi:10.1056/NEJMsa1803388.

⁴Werner RM, Emanuel EJ, Pham HH, Navathe AS. (2021). The Future of Value-Based Payment: A Road Map to 2030. Leonard Davis Institute. <https://ldi.upenn.edu/our-work/research-updates/the-future-of-value-based-payment-a-road-map-to-2030/>.

⁵Navathe AS, Emanuel EJ, Shenfeld DK. Expanding VBP: Fixing Design Flaws. *Health Affairs Forefront*, April 23, 2024. DOI: 10.1377/forefront.20240418.617238.

⁶Shenfeld DK, Navathe AS, Emanuel EJ. The Promise and Challenge of Value-Based Payment. *JAMA Internal Medicine*. Forthcoming May 2024.

data and modeling for actuarial risk; and (3) experimentation and protection from failure.⁷

Specific steps that Congress or CMS should take to improve the uptake of these models include ongoing conversations with stakeholders and participants about reasons for participation to further improve and strengthen considerations from the aforementioned highlighted lessons. Up-front investment is also crucial, as changing care patterns to conform with these models often requires initial transformation such as hiring care coordinators and altering practice workflow if change is to be sustainable.

Question. What specific flexibilities would help Accountable Care Organizations to improve patient care quality and reduce costs, and what steps could Congress take to advance these types of flexibilities?

Answer. ACOs are a strong example of value-based care (VBC) models that have seen success with investment from CMS in testing various structures and dedication effort to revise as needed. The CMS Medicare Shared Savings Program (MSSP) has selected the most high-performing ACOs to evaluate the factors leading to increased success of these models on improving quality and reducing cost. We suggest that by allowing for further ACO-led innovation, without a “one-size-fits-all” approach, fitting the needs of each population served per ACO will be more attainable.

The newly announced ACO Primary Care Flex model beginning in January 2025 is one example of a well-designed model that offers increased flexibility for primary care. It includes a prospective primary care payment (PPCP) that will shift payment for primary care away from visit-based FFS payment to enhance the predictability and amount of primary care funding for low revenue ACOs, increasing their flexibility to meet the needs of people with Medicare.⁸ It also includes a one-time up-front advanced shared savings payment to cover onboarding practice transformation costs of joining the model.

Another flexibility to help ACOs improve quality and reduce costs is improving their overlap with episode-based models through hierarchical payment structures.⁹ Creating flexibility for patients in ACOs to still be treated through episode-based payments as proposed in the new TEAM model is one example of how this can be accomplished, as well as by facilitating improved data sharing between ACOs and specialists.

Lastly, additional flexible support should be directed toward ACOs serving beneficiaries who face higher social burden. This approach is seen in ACO REACH with its Health Equity Benchmark Adjustment. However, these approaches will require empirical justification beyond solely conceptual support.¹⁰

Question. Artificial intelligence (AI) has the potential to mitigate administrative burden and enhance health-care quality, including in the context of Medicare. That said, some clinicians have raised concerns around the program’s inability to keep pace with AI-enabled tool development through its coverage and payment policies, undercutting access, especially for smaller practices.

What use cases for AI-enabled tools and technologies seem most promising in the context of clinician care?

Answer. AI-enabled tools have the potential to handle more menial and repetitive tasks for clinicians. There is a lot of promise in imaging specifically, with tools trained to detect signs of disease to be flagged for a more detailed review by clinicians. This type of technology is already being introduced to interpret imaging for pulmonary nodules, intracranial hemorrhage risk, diabetic retinopathy, cardiac

⁷ Shenfeld DK, Navathe AS, Emanuel EJ. Expanding VBP: Overcoming Implementation Barriers. *Health Affairs Forefront*, April 24, 2024. DOI: 10.1377/forefront.20240422.791880.

⁸ ACO Primary Care Flex Model. <https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model>.

⁹ Shrank WH, Chernew ME, Navathe AS. Hierarchical Payment Models—A Path for Coordinating Population- and Episode-Based Payment Models. *JAMA*. 2022 Feb 1;327(5):423–424. doi: 10.1001/jama.2021.23786.

¹⁰ Navathe AS, Liao JM. Embedding Equity in Financial Benchmarks: Changes to the Health Equity Benchmark Adjustment. *Health Affairs Forefront*. 28 Sep 2023. <https://www.healthaffairs.org/content/forefront/embedding-equity-financial-benchmarks-changes-health-equity-benchmark-adjustment>.

ultrasound, and others.^{11,12} This type of AI-enabled tools supplement physician practice and create efficiencies which allow clinicians to spend more time performing higher-level tasks.

Beyond established uses for imaging, AI is currently being piloted in primary care settings to draft responses to patient portal messages and draft clinic notes with ambient listening technology. This can enable physicians to spend less time on the computer and more time with their patients, a win-win for the system, clinician well-being, and patient satisfaction. Furthermore, AI can be used to streamline administrative requirements such as billing and documentation as well as prior authorization requirements. However, it is imperative to train these algorithms on a representative dataset with continual monitoring of outcomes to promote equity. These topics were discussed in an executive order from President Biden as well as a Health Plan Management System memorandum from CMS.^{13,14}

Question. What steps should CMS and Congress take to ensure adequate coverage and reimbursement for appropriate AI-enabled tools in this context?

Answer. Value-based models create incentives to use new AI technologies that improve efficiency. Rather than adding new codes for each new technology, a hybrid payment with a population-based payment would enable practices to decide which AI technologies best fit their needs and those of their patients. The use of AI-enabled tools can in some contexts be self-funding, as the efficiencies they create will allow clinicians to provide more care to more patients, drawing in more reimbursement without major changes in funding structure. Appropriately designing incentives outside of value-based models can be much more challenging.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. The Center for Medicare and Medicaid Innovation (CMMI) receives \$10 billion in mandatory funding every decade. The nonpartisan Congressional Budget Office (CBO) has found that CMMI has not lowered Medicare spending. Separately, CBO has found the Medicare Shared Savings Program (MSSP) was not a factor in the slower growth of Federal health-care spending.

Are the spending impacts on Medicare from CMMI and MSSP each validated by an independent, third-party organization? If not, why would that be important?

Answer. While no independent organization has been formally commissioned to conduct an evaluation of MSSP outside of CBO, many academic scholars have independently evaluated the effects of MSSP and found favorable results concentrated among physician-led ACOs.¹⁵ What appears to be a lack of contribution by MSSP to the growth of Federal health spending may actually be created by a measurement challenge. Practice change among clinicians both within and outside of demonstration projects, as well as overlapping demonstrations, creates “control group contamination,” making it look like demonstration projects did not save money when in reality they catalyzed broader systemwide transformation observed in the flattening of national health spending.¹⁶

While the spending impacts of CMMI as a whole were measured by CBO, CMMI itself commonly commissions government-contracted entities such as the Lewin Group and Mathematica to evaluate its demonstration projects. Furthermore, it is

¹¹ Gonzalez-Smith J, Shen H, Silcox C. Moving Ahead of the Pack: Understanding Health System Priorities on AI-Enabled Clinical Decision Support. *Biomedical Instrumentation & Technology*. 2022;56(4):119–23.

¹² Halabi, SS. Artificially Practical in Every Way. *Journal of the American College of Radiology*. Volume 17, Issue 11. 2020, Pages 1361–1362. ISSN 1546–1440. <https://doi.org/10.1016/j.jacr.2020.09.063>.

¹³ Executive Order on the Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence. 30 Oct 2023. <https://www.whitehouse.gov/briefing-room/presidential-actions/2023/10/30/executive-order-on-the-safe-secure-and-trustworthy-development-and-use-of-artificial-intelligence/>.

¹⁴ Frequently Asked Questions Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F). CMS. 6 Feb 2024. <https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf>.

¹⁵ McWilliams JM, Hatfield LA, Landon BE, Hamed P, Chernew ME. Medicare Spending after 3 Years of the Medicare Shared Savings Program. *N Engl J Med*. 2018 Sep 20;379(12):1139–1149. doi: 10.1056/NEJMsa1803388. Epub 2018 Sep 5. PMID: 30183495; PMCID: PMC6269647.

¹⁶ Navathe AS, Boyle CW, Emanuel EJ. Alternative Payment Models—Victims of Their Own Success? *JAMA*. 2020;324(3):237–238. doi:10.1001/jama.2020.4133.

important to note that the purpose of CMMI is not solely to lower spending, but also to improve quality.¹⁷ Growth in spending is only a problem if it is not accompanied by commensurate gains in outcomes. For example, while some of CMMI's demonstration projects may not have decreased spending overall, they did decrease hospitalizations and emergency department visits,¹⁸ suggesting that we are realizing quality gains for those dollars spent.

Question. Congress and the Centers for Medicare and Medicaid Services (CMS) have access to several advisory committees to inform us on how to move Medicare's fee-for-service payment system to a more outcomes-based model. These committees include the American Medical Association's RVS Update Committee, the Medicare Payment Advisory Commission—which you serve on—and the Physician-Focused Payment Model Technical Advisory Committee.

Are these committees effective at providing actionable recommendations to move our health-care system to be outcomes-based? If not, what reforms should be made to them?

Answer. Each of these committees have an important role to play in advising Congress and CMS. I believe that the roles of the RVS Update Committee, the Medicare Payment Advisory Commission are well defined, and that they are able to be effective in their mission. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) role has been less clear as their recommendations have not been implemented. To implement the recommendations of PTAC there needs to be a greater ability to create Value Based Models which are designed to engage specialists. By having a more proactive system CMS will have a greater ability to get reforms into practice.

Further, in order to be more effective, CMS requires a reexamination of the fee-for-service weights, but also the methodology and process by which the weights are created. I propose an independent group, comprised of experienced representatives from many specialties, and free of any interest in the results themselves. A group of this kind will be well suited to the task of creating weights which incentivize the form of practice which will achieve the greatest outcomes most efficiently.

Question. CMS has the authority to add additional procedure codes, which can allow for additional medical services to be covered under Medicare. Data shows that CMS rulemaking expanded annual Medicare spending by \$6 billion in 2016, \$10 billion in 2017, and \$6 billion in 2018.

Should Congress be concerned about these regulatory spending increases? How does this impact Medicare's long-term solvency?

Answer. CMS's introduction of procedural codes with the intent of improving care coordination—especially among beneficiaries with chronic conditions—has unfortunately resulted in additional administrative burden for physicians and other health-care providers; thereby affecting care quality and worsening fragmentation. Adding billing code upon billing code increases administrative complexity while failing to appropriately pay primary care practices for all the services they provide off of the fee schedule, an estimated 25 percent of their activities. Studies show that 60 percent of primary care visits deliver services that are not reportable in CPT (Current Procedural Terminology) codes.¹⁹ Examples of these services include checking insurance coverage for patients, addressing social determinants of health during visits, and discussing medication options.

In the short term, the deferred depletion of the Hospital Insurance (HI) trust fund coming at within 6 years of project depletion (projected depletion at 2026 in 2020, 2026 in 2021, and 2028 in 2022) can, in part, be attributed to the COVID-19 pandemic.²⁰ However, the Medicare trustees reported that the pandemic led to a significant rise in unemployment, causing a decline in payroll tax revenue to the HI trust fund. Spending grew due to expenses for COVID-19 treatment, testing, and vaccine distribution, along with advance payments to providers. Trustees project that the

¹⁷ Innovation Center Strategy Refresh. 2021. CMMI. <https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper>.

¹⁸ Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Evaluation Report. Mathematica. 2023 Dec. <https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report>.

¹⁹ Young RA, Burge S, Kumar KA, Wilson J. The Full Scope of Family Physicians' Work Is Not Reflected by Current Procedural Terminology Codes. *J Am Board Fam Med*. 2017 Nov-Dec;30(6):724–732. doi: 10.3122/jabfm.2017.06.170155. 23.

²⁰ #s from—<https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/>.

spending effects of the pandemic will not have a large effect on the financial status of the Medicare program beyond 2028.

In the long run, Medicare faces financial strain from rising health-care costs, increasing beneficiary enrollment, and an aging population. This growth in Medicare spending stresses the Federal budget, hastens the depletion of the Part A trust fund, and raises Medicare premiums, deductibles, and cost sharing for beneficiaries.²¹ Various changes have been suggested to tackle Medicare's fiscal issues. Proposals include raising the Medicare eligibility age and shifting to a premium support model. Additionally, the Inflation Reduction Act of 2022 seeks to limit Medicare's prescription drug spending by having the Federal Government negotiate drug prices in Medicare and requiring drug companies to provide rebates for price hikes that exceed inflation. CBO projects that the drug price negotiation measures in the Inflation Reduction Act will save Medicare \$98.5 billion over a decade (2022–2031).²²

In summary, it is understandable to be concerned about spending increases and to assess the value. The spending that increases value to beneficiaries and taxpayers may be warranted. These spending increases have not resulted in big impacts to the HI trust fund but rather come from general revenue from Medicare. Of note, however, is the need for CMS to have authority to bring new technologies and services into Medicare, as this the only way that Medicare FFS can evolve.

Question. You stated in your written testimony that “simply adding more dollars to the current system is unlikely to address the chronic care crisis in Medicare. Instead, thoughtful design is needed.”

Can you point to an example where less Medicare outlays produced better health outcomes? How was that efficiency achieved?

Answer. Investing in a robust primary care infrastructure may be crucial for a cost-efficient system that produces more health for each dollar spent. The U.S. already systematically underinvests in primary care, declining from 6.4 percent in 2013 to 4.6 percent in 2020. Medicare spends an estimated 4 percent of its total spending on primary care.²³ Despite this, geographic regions within the U.S. that have more primary care providers achieve greater health with lower total spending. For example, Medicare spends 25 percent less per beneficiary in states with many primary care providers compared to those with few.²⁴ There are examples of State-level investments in primary care that yielded overall savings. For example, Oregon's Primary Care Home Program produced \$13 in savings for every \$1 increase in primary care expenditures, saving \$240 million during its first 3 years.²⁵

CMS's Medicare Shared Savings Program (MSSP) saved Medicare \$1.8 billion in 2022 compared to spending targets for the year. The program has generated savings for a substantial number of years. In 2022, an estimated 63 percent of MSSP participating ACOs earned payments for their performance, with low-revenue ACOs (with at least 75 percent primary care clinicians) had \$294 per capita in net savings. These promising results emphasize achieved efficiency, showing the ability for saved dollars to align and bolster improved care outcomes.

Question. In your written testimony, you stated, “the billing cost for a visit has been estimated to be \$20.49, exceeding CMS's initially proposed \$15 FFS payment for a phone call or other ‘virtual check-in’ visit.”

Is it possible to lower the cost burden of submitting a bill for a provider? How do we make the billing more efficient and cost less?

Answer. The most efficient way to lower the cost burden of submitting a bill is by eliminating the need to submit a bill at all. This is the approach of population-based payments (PBP), the capitated portion of hybrid payments. Folding payments

²¹ *Ibid.* [KFF].

²² Explaining the Prescription Drug Provisions in the Inflation Reduction Act—KFF.

²³ Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Intern Med.* 2019 Jul 1;179(7):977–980. doi: 10.1001/jamainternmed.2018.8747.

²⁴ Baicker K, Chandra A. Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care. *Health Affairs* (Millwood). 2004 Jan–Jun; Suppl Web Exclusives: W4–184–97. doi: 10.1377/hlthaff.w4.184.

²⁵ Gelmon S, Wallace N, Sandber B, Petchel S, Bouranis N. 2016 September. Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings. <https://www.oregon.gov/oha/HPA/dsi-pcpcch/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf>.

for selected fee-based activities into a PBP can relieve providers of the time and effort required to submit a bill for reimbursement. They can instead be reimbursed for that same activity through a stable and predictable population-based payment and spend that extra time on direct patient care.

Beyond folding fees for certain services into a population-based payment, the PBP itself can support a physician practice to hire an administrator whose job it is to submit claims to Medicare or purchase an AI technology system which can streamline bill submission. A portion of the estimated cost of billing is in the opportunity cost of spending time with patients.^{26, 27} PBPs may free up physicians to practice at the top of their license and spend their time with patients, hiring administrators to focus on streamlining billing for a given practice. However, this approach is less than ideal, because it is still spending Medicare's dollars on administrative costs. Other approaches may include a single transparent set of payment rules with clear explanations and descriptions, a single claim form, and standard rules of submission.^{28, 29}

Question. A common concern from Iowa providers is the lack of preparation and notice for final payment rules from CMS. When final payment rules are set a couple of months or less from the start of the payment rule's implementation date, providers do not have time to prepare or adjust to new payment policies and administrative requirements. This includes changes to value-based care efforts.

Should there be a longer preparation period (*e.g.*, 6 months, 1 year) for providers to adjust to new payment policies and administrative requirements under Medicare? What effect would that have? Alternatively, should payment policies and administrative requirements remain consistent for more than 1 year except for newer input data (*e.g.*, inflationary or economic factors)?

Answer. Continual consideration for improvements to current payment rules and concurrent regulations will benefit stakeholders across Medicare. CMS should continue efforts to balance providing sufficient time for notice while also allowing for the ability for modifications to best evolve the program and meet beneficiaries needs.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. There are approximately 700,000 Texans and 12.2 million Americans who are jointly enrolled in Medicaid and Medicare. This includes many people with multiple chronic conditions. Medicare and Medicaid currently often don't coordinate care for these individuals. This can lead to poorer outcomes for patients and a more costly and ineffective health-care system overall.

I introduced the Delivering Unified Access to Lifesaving Services (or DUALS) Act with Senators Cassidy, Carper, Warner, Scott of South Carolina, and Menendez last month. This bill would require States to develop a unified health plan for these beneficiaries to help streamline our health-care system. The DUALS Act would also ensure this vulnerable patient population receives comprehensive care for their chronic health conditions.

Can you speak to how improving care coordination for dual eligible beneficiaries will help those with chronic conditions in particular?

Answer. Chronic conditions, like diabetes and hypertension, require consistent care to prevent acute hospitalizations. Barriers to primary care reduce consistency in the provision of care, and may lead to an acute hospitalization. Beneficiaries with chronic conditions, and those who are dual eligible, encounter more barriers to pri-

²⁶ Tseng P, Kaplan RS, Richman BD, Shah MA, Schulman KA. Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System. *JAMA*. 2018;319(7):691–697. doi:10.1001/jama.2017.19148.

²⁷ Gottlieb JD, Shapiro AH, Dunn A. The Complexity of Billing and Paying for Physician Care. *Health Aff (Millwood)*. 2018 Apr;37(4):619–626. doi: 10.1377/hlthaff.2017.1325. PMID: 29608348.

²⁸ Blanchfield BB, Heffernan JL, Osgood B, Sheehan RR, Meyer GS. Saving billions of dollars—and physicians' time—by streamlining billing practices. *Health Aff (Millwood)*. 2010 Jun;29(6):1248–54. doi: 10.1377/hlthaff.2009.0075. Epub 2010 Apr 29. PMID: 20430822.

²⁹ Young RA, Bayles B, Hill JH, Kumar KA. Family physicians' opinions on the primary care documentation, coding, and billing system: a qualitative study from the residency research network of Texas. *Fam Med*. 2014 May;46(5):378–84. PMID:24915481.

mary care.³⁰ Improving care coordination has the potential to reduce these barriers by shifting some of the burden of managing their care from the patient to care providers. Coordinated care also fosters collaboration between specialists. Coordinated care has been shown to reduce ED and acute care hospitalizations in beneficiaries generally,^{31,32} and in chronic care beneficiaries specifically.^{33,34}

Question. How does streamlining care coordination support providers in addition to patients?

Answer. Streamlining care coordination has the potential to reduce administrative burden on providers. Physicians spend a significant amount of time performing administrative tasks which drains mental energy and draws time away from patients.³⁵ Streamlining these burdens can reduce physician burnout.³⁶ Less time spent in administrative tasks can also increase physician throughput, allowing physician to attend to more patients but also earn more dollars for their practice while providing useful care.³⁷

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. In your testimony, you emphasize that in order to improve chronic disease outcomes, there must be changes in the way physicians deliver care. Specifically, you highlight issues with fragmentation within the fee-for-service reimbursement system that places overly burdensome administrative challenges onto providers.

I know you allude to this in your testimony, but can you just expand on some of these fragmentation issues and, specifically, some of the day-to-day effects of seemingly endless new billing codes being added by CMS and how that affects providers and their ability to care for their patients?

Answer. Some of these fragmentation issues emerge because of the sheer number of physicians that each patient with chronic disease sees per year. Over one-third of all Medicare beneficiaries saw 5 or more different physicians in 2019, a number that is likely higher among patients with chronic disease.³⁸ As the clinical workforce becomes increasingly subspecialized, a patient with diabetes, chronic obstructive pulmonary disease (COPD), and chronic kidney disease may see a primary care physician, endocrinologist, dietitian, pulmonologist, and nephrologist. The PCP is tasked with serving as a “quarterback,” communicating with multiple different physicians.

³⁰ Chatterjee P, Liao JM, Wang E, Feffer D, Navathe AS. Characteristics, utilization, and concentration of outpatient care for dual-eligible Medicare beneficiaries. *Am J Manag Care*. 2022 Oct 1;28(10):e370–e377. doi: 10.37765/ajmc.2022.89189. PMID: 36252177; PMCID: PMC10084394.

³¹ Tessa van Loenen, Michael J van den Berg, Gert P Westert, Marjan J Faber. Organizational aspects of primary care related to avoidable hospitalization: A systematic review, *Family Practice*, Volume 31, Issue 5, October 2014, Pages 502–516. <https://doi.org/10.1093/fampra/cmu053>.

³² Aldo Rosano, Christian Abo Loha, Roberto Falvo, Jouke van der Zee, Walter Ricciardi, Gabriella Guasticchi, Antonio Giulio de Belvis. The relationship between avoidable hospitalization and accessibility to primary care: A systematic review, *European Journal of Public Health*, Volume 23, Issue 3, June 2013, Pages 356–360. <https://doi.org/10.1093/eurpub/cks053>.

³³ Oh NL, Potter AJ, Sabik LM, et al. The association between primary care use and potentially-preventable hospitalization among dual eligibles age 65 and over. *BMC Health Serv Res* 22, 927 (2022). <https://doi.org/10.1186/s12913-022-08326-2>.

³⁴ R.J. Wolters, J.C.C. Braspenning, M. Wensing. Impact of primary care on hospital admission rates for diabetes patients: A systematic review, *Diabetes Research and Clinical Practice*, Volume 129, 2017, Pages 182–196, ISSN 0168–8227. <https://doi.org/10.1016/j.diabres.2017.05.001>.

³⁵ J. Marc Overhage, David McCallie. Physician Time Spent Using the Electronic Health Record During Outpatient Encounters: A Descriptive Study. *Ann Intern Med*.2020;172:169–174. [Epub 14 January 2020]. doi:10.7326/M18–3684.

³⁶ Kelly J, Thomas Craig, Van C. Willis, David Gruen, Kyu Rhee, Gretchen P. Jackson, The burden of the digital environment: A systematic review on organization-directed workplace interventions to mitigate physician burnout, *Journal of the American Medical Informatics Association*, Volume 28, Issue 5, May 2021, Pages 985–997. <https://doi.org/10.1093/jamia/ocaa301>.

³⁷ Youn S, Geismar HN, Pinedo M. (2022). Planning and scheduling in healthcare for better care coordination: Current understanding, trending topics, and future opportunities. *Production and Operations Management*, 31(12), 4407–4423. <https://doi.org/10.1111/poms.13867>.

³⁸ Barnett ML, Bitton A, Souza J, Landon BE. Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000 to 2019. *Ann Intern Med*. 2021 Dec; 174(12):1658-1665. doi: 10.7326/M21-1523. Epub 2021 Nov 2. Erratum in: *Ann Intern Med*. 2022 Oct;175(10):1492.

This can require upwards of 50 distinct interactions between a PCP and other providers to manage one condition for one patient over a 3-month period.³⁹ Each of these interactions risks information falling through the cracks. Despite the fact that this communication is one of the most important roles of the PCP, it is something they cannot directly bill for in the current FFS system. Implementing a population-based hybrid payment would compensate the PCP for spending time on these critical activities as well as financially support them to hire a care coordinator or case manager to smooth these interactions.

Beyond fragmentation between multiple specialists, fragmentation also arises because of the increasing number of billing codes. CMS continues to add new codes in a valiant effort to compensate PCPs for their work. While this is well-intentioned, simply adding more dollars and more billing codes to the existing system will not address the challenge of fragmentation; rather, it will exacerbate it. Adding more billing codes places a band-aid on the problem of primary care compensation—namely, that it is a fee-for-service system operating in a health-care environment that is increasingly fast-paced, technology dependent, subspecialized, and complex. Instead, the system must be reimagined with a new type of compensation altogether to account for the rapidly changing demands of modern care delivery for patients with chronic disease. Hybrid payments offer a promising approach to increase financial stability and reverse fragmentation and administrative burden created by “tick-tack” codes.

Question. As part of the Merit-based Incentive Payment System (MIPS), physicians must be compliant in promoting interoperability as part of their reimbursement, which helps to facilitate the sharing of data between various providers.

I have long been an advocate for health IT initiatives that can improve efficiencies and reduce costs in the health-care system, and I believe that sharing information between providers through an interoperable network has immense upside, so long as there are safeguards to protect patient privacy and ensure taxpayer funds are spent appropriately.

However, there continue to be challenges to physicians meeting interoperability metrics, like information blocking for example in which an individual or entity impedes the delivery or utilization of an electronic health record, making interoperability impossible.

In your view, how have practices been impacted by information blocking?

Are you aware of instances in which the timeliness or quality of the care physicians are able to provide patients has been impacted by a limited ability or complete inability to access electronic health records?

Furthermore, beyond information blocking, what other challenges persist in physicians accessing patients’ health information electronically despite the billions of dollars spent to implement electronic health IT and interoperability?

Answer. The 21st Century Cures Act, enacted in 2016, had an important component to improve the exchange of electronic health information by promoting interoperability, preventing information blocking, and enhancing the usability, accessibility, privacy, and security of health information technology.⁴⁰ Yet, interoperability remains a challenge in health care, impacting the efficiency and quality of care. A recent observational study revealed a significant, positive, and cyclic relationship among three capabilities of health information exchange, interoperability, and medication reconciliation, suggesting that a decline in one could lead to declines in the others, highlighting the need for policies to address these gaps to ensure improved medication reconciliation and overall patient safety.⁴¹ Policy measures targeting key elements of high-functioning EHRs, like interoperability, could have broad impacts on other system capabilities.

Hindered access to electronic health records leads to delays in patient care while limiting a physician’s ability to make timely informed decisions. However, the expense of implementing EHRs continues to be a significant obstacle to their adoption. According to the Michigan Center for Effective IT Adoption, initial and ongoing an-

³⁹ Press MJ. Instant Replay—A Quarterback’s View of Care Coordination. *New England Journal of Medicine*. 2014;371:489–491. doi: 10.1056/NEJMp1406033.

⁴⁰ The Office of the National Coordinator for Health Information Technology (ONC)’s Cures Act Final Rule. *Federal Register* as 85 FR 25642, May 1, 2020.

⁴¹ Gerald E, Herrin J, and Horwitz LI. An Observational Study of the Relationship Between Meaningful Use-Based Electronic Health Information Exchange, Interoperability, and Medication Reconciliation Capabilities. *Medicine* 96.41 (2017): e8274.

nual costs for EHR implementation can vary from \$15,000 to \$70,000 per provider, influenced by whether the deployment is server-based or web-based.⁴²

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. In your testimony, you noted that Medicare spends an estimated 4 percent of its total spending on primary care, which is about half of what other developed countries spend. You also noted, more than two-thirds of the Medicare population is diagnosed with two or more chronic conditions, and 15 percent of the Medicare population has six or more conditions.

Can you expand on why increased and more functional investments in primary care could result in better outcomes for patients, especially for older adults? How is this likely to result in long-term costs savings?

Answer. Increased and more functional investments in primary care could result in better outcomes for patients by focusing on prevention to keep them healthy and out of the hospital. Any effort to improve chronic disease care will require a change to the way health care is delivered, a different “model of care” to address fragmentation. It will require physician groups to be able to invest in new capabilities; use technologies like telehealth when they are safe, efficient, and effective; and expand the role of staff practices, including care coordinators and case managers. For example, there is a growing workforce of nurse practitioners in primary care who help bolster access and improve care coordination, demonstrating successful care model shifts. A crucial element to enable a new model of care, however, is substantial change to physician payment. Simply adding more dollars to the current system is unlikely to address the chronic care crisis in Medicare. Instead, complete care redesign is needed.

A natural place to start is to invest more in primary care, empowering PCPs to act as the “quarterback” or “point guard” of a patient’s care team. Robust primary care has consistently demonstrated an improvement in population health and reduction in health disparities.⁴³ Despite this, the United States systemically underinvests in primary care. Expenditure on primary care in the U.S. has declined over the past decade, ranging from 6.2 percent in 2013 to 4.6 percent in 2020 across all insurance types. Medicare spends an estimated 4 percent of its total spending on primary care,^{44, 45, 46} about \$15 billion per year, which is half that of many other developed countries.⁴⁷ In contrast, we spend more on inpatient care and hospitalizations than other nations. Within the U.S., primary care is systematically underinvested relative to other specialties,^{48, 49} despite the fact that PCPs play the most central role in a patient’s health and face the cognitively and logistically complex task of care coordination and integration. Procedural specialties are compensated

⁴² Reisman M. EHRs: The Challenge of Making Electronic Data Usable and Interoperable. *Pharmacy and Therapeutics* 42.9 (2017): 572.

⁴³ Jabbarpour Y, Petterson S, Jetty A, Byun H, Robert Graham Center. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. *Milbank Quarterly*. 2023 Feb. https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf.

⁴⁴ New “Scorecard” Finds Primary Care Funding and Physician Workforce Are Shrinking. *AA of Family Physicians*. February 24, 2023. <https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/primary-care-scorecard.html>.

⁴⁵ Jabbarpour Y, Petterson S, Jetty A, Byun H, Robert Graham Center. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. *Milbank Quarterly*. 2023 Feb. https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf.

⁴⁶ Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Intern Med*. 2019 Jul 1;179(7):977–980. doi: 10.1001/jamainternmed.2018.8747.

⁴⁷ OECD Country Health Profiles, 2023. <https://www.oecd.org/els/health-systems/primary-care.htm>.

⁴⁸ Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Intern Med*. 2019;179(7):977–980. doi:10.1001/jamainternmed.2018.8747v.

⁴⁹ Zuckerman S, Merrell K, Berenson RA, Cafarella Lallemand N, and Sunshine J. 2015. Re-align Physician Payment Incentives in Medicare to Achieve Payment Equity Among Specialties, Expand the Supply of Primary Care Physicians, and Improve the Value of Care for Beneficiaries. Washington, DC: Urban Institute, Social & Scientific Systems Inc.

significantly more than primary care and other office-based specialties.^{50, 51, 52} Changing fee schedule weights alone will not fix this; studies demonstrated that a recent upweighting of reimbursement for office visits led to only a 2 percent decrease in the Medicare payment gap between primary care and specialty physicians (from a gap of \$40,259.80 to one of \$39,434.70).⁵³

Beyond mobilizing more dollars into primary care, we need to enable PCPs to invest in new capabilities and grant them more flexibility. One potential path would be to provide PCPs with consistent per-beneficiary per-month (PBPM) payments in addition to certain fee-for-service payments.⁵⁴ These PBPM payments would be designed to cover the estimated 25 percent of PCP activities that are not currently captured in the Medicare Physician Fee Schedule, such as care coordination, communication with other providers, addressing social determinants of health, and improving patient and caregiver health literacy. This would balance the goals of preserving access through FFS payments while enabling PCPs to practice more patient-centered, rather than visit-centered, care. Ultimately, it would unshackle PCPs from a system that tries to capture every activity across thousands of codes. PBPM payments enable PCPs to invest in sustainable practice infrastructure transformation such as hiring case managers and care coordinators or integrating technology and team-based care. This care model redesign is of particular importance for improving the health of patients with multiple chronic conditions while reducing wasteful administrative complexity.

Hybrid primary care payments cannot be implemented at scale without congressional action. The Centers for Medicare and Medicaid Services (CMS) have conducted several demonstration projects implementing hybrid payments (*e.g.*, Comprehensive Primary Care Plus). It also has the authority to—and should—implement hybrid payments in the MSSP⁵⁵ the largest accountable care program in Medicare. However, moving past demonstrations to impact Medicare beneficiaries nationwide will require congressional action to grant CMS the appropriate authority.

The evidence for hybrid payments is promising. Blue Cross Blue Shield of Hawaii, or Hawaii Medical Services Association (HMSA), has conducted what is perhaps the most rigorous test of hybrid payments for primary care to date in its Population-based Payments for Primary Care (3PC) model. The 3PC model is a hybrid model that shifted the majority of payments to PCPs to a risk-adjusted per-member per-month payment, while continuing to pay some services as FFS.

The transformative elements of HMSA's 3PC model relate to its large market share; across its commercial, Medicare Advantage, and Managed Medicaid lines of business, HMSA retains large shares of patients and revenue for most of its PCPs. The model led to marked improvements in quality, greater use of telehealth that predated the COVID-19 pandemic, and fewer low-value imaging tests.⁵⁶ This included increased rates of cost-effective prevention such as blood pressure control among patients with diabetes (2.7 percent differential increase), as well as greater cost-saving care such as a 5.5-percent differential increase in advance care planning

⁵⁰ Hsiao WC, Braun P, Yntema D, Becker ER. Estimating Physicians' Work for a Resource-Based Relative-Value Scale. *N Engl J Med*. 1988; 319:835–41.

⁵¹ Katz S, Melmed G. How Relative Value Units Undervalue the Cognitive Physician Visit: A Focus on Inflammatory Bowel Disease. *Gastroenterol Hepatol (NY)*. 2016 Apr;12(4):240–4.

⁵² Bodenheimer T, Berenson RA, Rudolf P. The Primary Care-Specialty Income Gap: Why It Matters. *Ann Intern Med*. 2007 Feb 20;146(4):301–6. doi: 10.7326/0003-4819-146-4-200702200-00011.

⁵³ Neprash HT, Golberstein E, Ganguli I, Cherner ME. Association of Evaluation and Management Payment Policy Changes with Medicare Payment to Physicians by Specialty. *JAMA*. 2023;329(8):662–669. doi:10.1001/jama.2023.0879.

⁵⁴ Berenson RA, Shartz A, Pham HH. Beyond demonstrations: Implementing a primary care hybrid payment model in Medicare. *Health Affairs Scholar*. 2023 Aug;1(2):qxad024.

⁵⁵ Commonwealth Fund. Response to Request for Information on HHS Initiative to Strengthen Primary Health Care from the Office of the Assistant Secretary for Health, Department of Health and Human Services. https://www.commonwealthfund.org/sites/default/files/2022-08/TO%20ATTACH%20AS%20DOWNLOAD_Commonwealth%20Fund_OASH%20Primary%20Care%20RFI_7.29.22.pdf.

⁵⁶ Dinh CT, Linn KA, Isidro U, Emanuel EJ, Volpp KG, Bond AM, Caldarella K, Troxel AB, Zhu J, Yang L, Matloubieh SE, Drye E, Bernheim S, Lee EO, Mugiishi M, Endo KT, Yoshimoto J, Yuen I, Okamura S, Tom J, Navathe AS. Changes in Outpatient Imaging Utilization and Spending Under a New Population-Based Primary Care Payment Model. *J Am Coll Radiology*. 2020 Jan;17(1 Pt B):101–109. doi: 10.1016/j.jacr.2019.08.013. PMID: 31918865.

(Exhibit 2).⁵⁷ In fact, unlike other States where primary care practice finances were massively disrupted by the COVID-19 pandemic, practices in Hawaii were protected financially, as PCPs were well equipped to care for patients effectively in a remote fashion because they had already made such infrastructure investments. The experience and transformative successes in Hawaii underscore the stability and ability to invest that hybrid payments can impart to primary care practices.

Beyond private payers in Hawaii, CMS has been testing “advanced primary care models” at a national level using hybrid payments in Medicare for over a decade with promising “leading indicator” results. These models led to fewer emergency department visits and hospitalizations, while producing modest gains in chronic disease management and prevention. In Comprehensive Primary Care (CPC, 2012–2016), hospitalizations and emergency department visits increased by 2 percent less among participating practices.⁵⁸ This represented a statistically significant relative reduction of 8,150 hospitalizations and 15,472 outpatient emergency department (ED) visits over the 4 years of the program. Importantly, practices with greater access to resources or more experience with care delivery transformation were more likely to reduce growth in expenditures (~2 percent). This highlights the importance of providing practices with resources for successful and sustainable transformation.

Comprehensive Primary Care Plus (CPC+, 2017–2021) similarly saw a 2-percent reduction in ED visits that emerged early and persisted across the 5 program years.⁵⁹ A 2-percent reduction in hospitalizations emerged in program years 3 and 4 and was driven by reductions in medical admissions, suggesting that these admissions were prevented by improved outpatient care. Furthermore, over the 5 years of the program, the percentages of beneficiaries who received all recommended services for diabetes increased by about 1 percentage point and of females who received breast cancer screening increased by about 1 percentage point. CPC+ had more favorable effects among concurrent MSSP participants, again suggesting that practices can build experience with care transformation with time and proper investment. These demonstrations suggest that transforming primary care payment can have important implications for beneficiaries with multiple chronic conditions, such as decreasing emergency department visits and hospitalizations while improving the delivery of robust well-integrated and well-coordinated primary care.

Another approach would be to continue expansion of alternative payment models (APMs), which increase accountability for cost and quality outcomes onto providers, shifting provider focus to value. This will require continued support for the CMS Innovation Center. There is some evidence that APMs can improve care for beneficiaries with both high and low burdens of chronic disease. A great example has been the Accountable Care Organization (ACO) model.

Question. Your testimony highlighted how fractured our current health-care system is and demonstrated that patients, especially those with chronic conditions, spend a lot of time trying to navigate that system. We also know that individuals who are dually eligible for Medicare and Medicaid often experience even more fragmented care due to poor care coordination. Additionally, average Medicare spending is higher for dual-eligibles across all services.

How could changes to how primary care services are delivered and paid benefit dually eligible beneficiaries?

Answer. Dual-eligible beneficiaries face a disproportionately high burden of chronic conditions compared to non-dual Medicare enrollees.⁶⁰ As a result, they seek a higher volume of specialty care. Therefore, they would get an outsized benefit from improvements in coordination.

⁵⁷ Navathe AS, Emanuel EJ, Bond A, Linn K, Caldarella K, Troxel A, Zhu J, Yang L, Matloubieh SE, Drye E, Bernheim S, Lee EO, Mugiishi M, Endo KT, Yoshimoto J, Yuen I, Okamura S, Stollar M, Tom J, Gold M, Volpp KG. Association Between the Implementation of a Population-Based Primary Care Payment System and Achievement on Quality Measures in Hawaii. *JAMA*. 2019 Jul 2;322(1):57–68. doi: 10.1001/jama.2019.8113.

⁵⁸ Evaluation of the Comprehensive Primary Care Initiative: Fourth Evaluation Report. Mathematica. 2018 May. <https://downloads.cms.gov/files/emmi/CPC-initiative-fourth-annual-report.pdf>.

⁵⁹ Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Evaluation Report. Mathematica. 2023 Dec. <https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report>.

⁶⁰ Kasper J, Watts MO, Lyons B. Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Family Foundation, 2010. <https://www.kff.org/wp-content/uploads/2013/01/8081.pdf>.

Question. Today's patients navigate a complex health system, while also facing the complexities of their own lives. We need a health workforce that can meet people where they are and address their specific barriers to good health. Community health workers have long filled this need by providing health-care navigation and social support in diverse communities across the Nation. They are versatile problem solvers who take the time to understand each client's situation and help restore them to their best possible health. But despite the significant value they bring to our health system, community health worker programs often rely on a patchwork of funding that comes and goes. In your testimony, you discussed how primary care practices can improve care for patients with multiple chronic conditions by hiring community health workers.

What are some barriers primary care providers currently face in hiring and sustaining these workers? How could a shift in payment models decrease these barriers?

Answer. CHWs can significantly improve the outcomes of their patients, especially those with multiple chronic conditions.⁶¹ Barriers that PCPs currently face in hiring CHWs are the lack of sustainable funding to support these staff members. Medicare began reimbursing for CHW activities effective January 1, 2024, but this merely added codes to the existing FFS system to allow CHWs to bill for their services. Unfortunately, this will be of no help to practices who do not have the capital to invest in these team members in the first place. Primary care practices do not have the capital to invest in these team members. A shift in payment models to hybrid payments could decrease these barriers by providing practices with a steady flow of population-based payments to support hiring lay health workers.

As of 2022, 19 States do not allow Medicaid payment for services provided by Community Health Workers (CHWs).⁶² Without this funding, CHWs must be funded through other means, often times by grants or community organizations.⁶³ This lack of funding is a barrier to utilizing these workers in those States. Value-based care models which incentivize providers to keep costs low through preventative care and practices will likely find value in hiring and sustaining these workers. A study by Penn's own IMPaCT program found that for every \$1 invested in a CHW program \$2.47 of savings were generated.⁶⁴ Additional programs like this could be implemented by providers searching for savings through better care coordination.

Question. Your testimonies and discussions at the hearing noted that the Merit-based Incentive Payment System (MIPS) is cumbersome for clinicians. The intention of MIPS is to foster performance improvements, leading to better outcomes for patients. You all mentioned that MIPS is burdensome and may not accurately capture the quality of care physicians provide.

Are there policy proposals that could be implemented to make MIPS more accurate and less burdensome?

Answer. Currently, MIPS requires reporting of quality metrics that may be out of touch with what providers find best for their patients or are excessively burdensome to monitor and report. While monitoring quality is important for patient safety and delivering high-quality care, the current approach designed by MIPS may create costs that outweigh its benefits. One study in JAMA Health Forum of 30 physician practice leaders across the U.S. found that an average of \$12,811 per physician was spent to participate in MIPS in 2019, and clinicians and administrators spent more than 200 hours per physician on MIPS-related activities.⁶⁵ In its 2018 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended elimi-

⁶¹ Knowles M, Crowley AP, Vasan A, Kangovi S. Community Health Worker Integration with and Effectiveness in Health Care and Public Health in the United States. *Annu Rev Public Health*. 2023 Apr 3;44:363–381. doi: 10.1146/annurev-publhealth-071521-031648. PMID: 37010928.

⁶² Sweta Halder and Elizabeth Hinton. State Policies for Expanding Medicaid Coverage of Community Health Worker (CHW) Services, KFF, Jan 23, 2023. <https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicare-coverage-of-community-health-worker-chw-services/>.

⁶³ *Ibid.*

⁶⁴ Kangovi S, Mitra N, Grande D, Long JA, and Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment. *Health Affairs* 2020 39:2, 207–213.

⁶⁵ Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum*. 2021 May 14;2(5):e210527. doi: 10.1001/jamahealthforum.2021.0527. PMID: 35977308; PMCID: PMC8796897.

inating MIPS and replacing it with a more streamlined quality system that is synergistic and supportive of physician effort.⁶⁶ Our own research highlights that MIPS may disproportionately negatively impact safety-net and rural providers.⁶⁷

Beyond reforming MIPS, Congress and HHS may have statutory authority to reform physician payment in other ways, including by establishing hybrid payments. Congress should clarify CMS's authority to broadly implement population-based payment through the Medicare Physician Fee Schedule (MPFS). In the meantime, MSSP offers an immediate opportunity for this to occur. Section 3022 of the ACA established that providers participating in an MSSP ACO are reimbursed according to standard Parts A and B payments, including the MPFS. However, according to Berenson et al., 2023, any provision of Medicare title 18 of the Social Security Act can be waived to carry out the MSSP under statutory waiver authority. This statute specifically mentions the possibility of implementing new payment methods.⁶⁸

MedPAC suggested in 2018 that Congress eliminate MIPS to instead attempt an alternative approach to incentivize high-quality care for traditional Medicare beneficiaries, due to the belief that within its current structure, MIPS will not achieve such a goal. believes that MIPS, as currently structured, will not achieve this goal.⁶⁹

Payment policy can help to rebalance quality versus quantity incentive for physicians and provider organization motivation. There is potential through policy reform to support clinicians' "intrinsic motivation" by encouraging systematic feedback provided to clinicians tied with opportunities for collaboration to improve care; CMS has programs such as Partnership for Patients and Conditions of Participation that demonstrate existing models that support providers to improve quality while avoiding substandard care for beneficiaries.⁷⁰

QUESTION SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. I am working on a bill to relieve providers excelling in the Medicare Shared Savings Program (MSSP), from prior authorization (PA) requirements in MA. The bill rewards providers in Accountable Care Organizations (ACOs) that generate savings for Medicare by granting an exemption from PA requirements for their MA beneficiaries. If an insurer believes there is a rationale for maintaining PA in such instances, this bill would require them to seek prior approval from the Centers for Medicare and Medicaid Services (CMS). I would welcome your thoughts and comments on this idea.

Answer. Prior authorization is used by insurers to constrain costs created by potentially unnecessary or low-value treatment. However, providers participating in ACOs should already face incentives to keep costs low and would therefore only be using expensive medications if they were truly beneficial for patient care. Consequently, prior authorization should be less necessary among ACOs who are succeeding in MSSP, because they would already be containing costs through the incentives created by accountable care arrangements. PA would only add to their administrative burden, likely raising costs rather than saving them because physicians should already be optimizing prescriptions due to ACO incentives.

One national survey of 49 ACOs found that they accomplish this by involving pharmacists directly in care, expanding the use of generics, and educating patients

⁶⁶The Medicare Payment Advisory Commission. Moving beyond the Merit-based Incentive Payment System, chapter 15. Report to Congress, 2018. Accessed April 24, 2024. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch15_sec.pdf.

⁶⁷Liao JM, Navathe AS. Does the Merit-based Incentive Payment System disproportionately affect safety-net practices? JAMA Health Forum. 2020;1(5):e200452. doi: 10.1001/jamahealthforum.2020.0452.

⁶⁸Berenson RA, Shartz A, Pham HH. Beyond demonstrations: implementing a primary care hybrid payment model in Medicare, Health Affairs Scholar, 1(2). August 2023. <https://doi.org/10.1093/haschl/qxad024>.

⁶⁹MedPAC, March 2018 Report to the Congress: Medicare Payment Policy. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar18_medpac_entirereport_sec_rev_0518-pdf/.

⁷⁰Berenson RA, Rice T. Beyond Measurement and Reward: Methods of Motivating Quality Improvement and Accountability. Health Serv Res. 2015 Dec;50 Suppl 2(Suppl 2):2155–86. doi: 10.1111/1475-6773.12413. Epub 2015 Nov 10. PMID: 26555346; PMCID: PMC5114714.

on therapeutic alternatives.⁷¹ Another survey of 46 ACOs identified strengths including the ability to integrate medical and pharmaceutical data into a single database and maintaining a formulary that encourages generic use when appropriate.⁷² However, this study found that ACOs will need more support to quantify the magnitude of cost offsets and therefore demonstrate the value of appropriate medication, use as well as create protocols to avoid medication duplication and polypharmacy. Regardless, the most successful ACOs are likely those who are most prepared to assume accountability for medication costs and optimize prescription value without the added burden of PA. Therefore, a bill limiting PA for top performers in MSSP could relieve providers of this additional administrative work and allow them to focus more on caring for their patients.

QUESTION SUBMITTED BY HON. MAGGIE HASSAN

Question. I am working with my colleagues on the Finance Committee to address discrepancies in Medicare reimbursement that disadvantage independent doctors. Older adults, and the Medicare program, often pay a huge markup for basic services if their provider's office is owned by a hospital.

For example, for a routine allergy test, a patient on traditional Medicare will pay around \$40 at an independent doctor's office, but would pay almost \$200 if that office is owned by a hospital, even if the actual hospital is miles away. Similarly, the Medicare program would pay the doctor around \$170 for the allergy test, but would pay a hospital-owned practice more than \$700 for the same exact service.

How do these imbalanced payments hold the Medicare program back from investing in high-quality, office-based care?

Answer. In 2021 and again more recently as of June of 2023, MedPAC recommended that Congress adopt more site-neutral payment policies for certain outpatient services to redistribute these dollars in a more balanced fashion.⁷³ The Commission recommended more closely aligning Medicare payment rates across ambulatory settings—hospital outpatient departments, ambulatory surgical centers, and freestanding physician offices—for selected services. These imbalanced payments hold the Medicare program back from investing in high quality, office-based care by setting up wrong incentives, leading to arbitrage as opposed to prioritizing access.

QUESTIONS SUBMITTED BY HON. MARSHA BLACKBURN

Question. As CMS begins implementing the Inflation Reduction Act's price-setting scheme, I am concerned about the impact on patient access for Part B drugs subjected to price controls beginning in 2028. As currently written, CMS will reimburse providers for negotiated Part B drugs based on the Maximum Fair Price plus 6 percent rather than the standard Average Sales Price (ASP) plus 6 percent. In the words of the Community Oncology Alliance, this change will "drastically cut reimbursement for Part B drugs, making it increasingly challenging for community oncology practices to administer drugs and keep their doors open." An analysis conducted by Avalere Health found that the IRA would lead to a minimum 49.5-percent Part B reimbursement cut for providers.

Additionally, depending on how CMS implements IRA price controls on Part B drugs, these payment cuts in Medicare could also affect the ASP of the drug, which is often used by private insurance companies for reimbursement to providers.

Have you examined the potential impact that IRA price controls for Part B drugs, if allowed to proceed in 2028, would have on your providers, practices, and the Medicare patients you serve?

⁷¹ Wilks C, Krisle E, Westrich K, Lunner K, Muhlestein D, Dubois R. Optimization of Medication Use at Accountable Care Organizations. *J Manag Care Spec Pharm.* 2017 Oct;23(10):1054–1064. doi: 10.18553/jmcp.2017.23.10.1054. PMID: 28944730; PMCID: PMC10397795.

⁷² Dubois RW, Feldman M, Lustig A, Kotzbauer G, Penso J, Pope SD, Westrich KD. Are ACOs Ready to be Accountable for Medication Use? *J Manag Care Spec Pharm.* 2020 Nov;26(11):1446–1451. doi: 10.18553/jmcp.2020.26.11.1446. PMID: 33119446; PMCID: PMC10390926.

⁷³ MedPAC, June 2023 Report to the Congress: Medicare Payment Policy. <https://www.medpac.gov/document/june-2023-report-to-the-congress-medicare-and-the-health-care-delivery-system/>.

Have you assessed the impact it could have on quality of care and patient outcomes?

Answer. This is a new focus area for our research center, and is an important topic. We hope to assess this in a more robust fashion to be able to report back in the future. Thank you for highlighting this relevant and emerging topic area.

Question. Medicare physician pay and its impact on patient access to care remains a significant issue for my constituents. Adjusted for inflation in practice costs, Medicare physician pay plummeted 29 percent from 2001 to 2024. Although Congress did act in the March 8th government funding package to reduce the 3.37-percent cut that went into effect on January 1, 2024, by an additional 1.68 percent, the 29-percent reduction in Medicare payments over the last 2 decades is reflective of this most recent congressional action. Plus, physicians are now set up for another steep payment cut at the end of this year.

Nonpartisan government stakeholders recognize the damaging impact these cumulative payment cuts have on patient access to care. Multiple Medicare trustee reports stated that “absent a change in the delivery system or level of update by subsequent legislation, the trustees expect access to Medicare-participating physicians to become a significant issue in the long term.”

Can you discuss some of the impacts of this pressing financial instability on physician practices, including consolidation, difficulty retaining staff, and trouble keeping their doors open amid rising costs?

Answer. Rising costs in Medicare are in part due to a combination of an aging population with rising rates of chronic disease as well as increasing administrative and technological burden. Our health system in the United States invests much more in hospital and acute care than it does in outpatient care, a ratio opposite that of other high-income nations such as Denmark and Norway.^{74,75} As a result, primary care practices may find themselves underfunded and unable to deliver the care they aspire to provide, especially in rural and underserved areas.

A fee-for-service (FFS) payment system causes PCPs to be dependent upon visit volume for revenue to keep their practices afloat. Shifting to a hybrid payment model can provide PCPs with stable, predictable population-based payments that can support their practices through fluctuations in visit volume and enable them to increase after-hours, virtual, or weekend care to best meet the needs of their population.⁷⁶

Consolidation of primary care practices has been shown to reduce total patient health-care spending by 16 percent.⁷⁷ While this reduction in spending is primarily driven by a 21-percent reduction in inpatient admissions, it is also due to a 13-percent reduction in primary care visits. This demonstrates how consolidation may decrease access to primary care. Increasing funds through population-based payment mechanisms may provide practices with the stable financial cash flow to keep their doors open, increasing access for Medicare patients with chronic conditions.

Of note, accounting for inflation in input costs is important, but we should be sure to distinguish between keeping pace with inflation versus adding more dollars to create better access and outcomes for beneficiaries.

Question. What available mechanisms do Congress and HHS have within current statutory authority to help provide adequate Medicare payments to physicians and ensure continued patient access to care? For example, alleviating the administrative burden on practices through reforms to the Merit-based Incentive Payment System?

Answer. Reforms to the Merit-based Incentive Payment System (MIPS) represent one mechanism to reduce administrative burden on practices. It is unclear in the current framework if MIPS can be reformed to be effective. Currently, MIPS requires reporting of quality metrics that may be out of touch with what providers find best for their patients or are excessively burdensome to monitor and report.

⁷⁴Denmark: Country Health Profile 2023, State of Health in the EU, OECD Publishing, <https://doi.org/10.1787/e4f0bee3-en>.

⁷⁵Norway: Country Health Profile 2023, State of Health in the EU, OECD Publishing, <https://doi.org/10.1787/256fd7cf-en>.

⁷⁶National Academy of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care Consensus Study Report, 2021. Accessed April 24, 2024. <https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care>.

⁷⁷Zhang J, Chen Y, Einav L, Levin J, Bhattacharya J. Consolidation of primary care physicians and its impact on healthcare utilization. *Health Econ.* 2021 Jun;30(6):1361–1373. doi: 10.1002/hec.4257.

While monitoring quality is important for patient safety and delivering high-quality care, the current approach designed by MIPS may create costs that outweigh its benefits. One study in *JAMA Health Forum* of 30 physician practice leaders across the U.S. found that an average of \$12,811 per physician was spent to participate in MIPS in 2019, and clinicians and administrators spent more than 200 hours per physician on MIPS-related activities.⁷⁸ In its 2018 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended eliminating MIPS and replacing it with a more streamlined quality system that is synergistic and supportive of physician effort.⁷⁹ Our own research highlights that MIPS may disproportionately negatively impact safety-net and rural providers.⁸⁰

Congress and HHS may also need to enable statutory authority to reform physician payment in other ways, including by establishing hybrid payments. Congress should clarify CMS's authority to broadly implement population-based payment through the Medicare Physician Fee Schedule (MPFS). In the meantime, MSSP offers an immediate opportunity for this to occur. Section 3022 of the ACA established that providers participating in an MSSP ACO are reimbursed according to standard Parts A and B payments, including the MPFS. However, according to Berenson et al. (2023), any provision of Medicare title 18 of the Social Security Act can be waived to carry out the MSSP under statutory waiver authority. This statute specifically mentions the possibility of implementing new payment methods.⁸¹

Question. Do these cuts disproportionately impact access to care in underserved areas?

Answer. Reductions in Medicare payments may affect access to care in rural and underserved areas. Because providers are currently dependent on volume, they may be forced to close or be acquired when payment rates or visit volumes fall. Establishing a stable population-based payment may help rural practices invest in sustainable practice transformation and remain open during periods of visit instability. For example, a population-based payment in Hawaii enabled them to transform their practice to increase the provision of telehealth, improving their practice stability when many others faced difficulty during the COVID-19 pandemic.⁸²

Question. Many patients have chronic heart conditions, and studies have shown how better cardiac care and rehabilitation after events reduces hospital readmissions. However, uptake for cardiac rehabilitation services remains low, which was affirmed by MedPAC's March 2024 report showing 1–3 percent across Medicare Advantage and Special Needs Plans, and 5–8 percent in Medicare fee-for-service.

Can we leverage more strategies focused on adherence and prevention to reduce health-care costs, such as the home care model used in Sustainable Cardiorespiratory Rehabilitation Services in the Home Act?

Answer. Some evidence (although limited) suggests an association between increased cost sharing and more inpatient care and less outpatient care; studies found in evaluating reducing or eliminating cost-sharing total costs did not rise.⁸³ The Medicare Advantage Value-Based Insurance Design (VBID) Model aims to remove certain obstacles to optimal health and health care. Examples include offering patients supplemental benefits such as lower costs for prescription drugs; grocery as-

⁷⁸ Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum*. 2021 May 14;2(5):e210527. doi: 10.1001/jamahealthforum.2021.0527. PMID: 35977308; PMCID: PMC8796897.

⁷⁹ The Medicare Payment Advisory Commission. Moving beyond the Merit-based Incentive Payment System, chapter 15. Report to Congress, 2018. Accessed April 24, 2024. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch15_sec.pdf.

⁸⁰ Lião JM, Navathe AS. Does the Merit-based Incentive Payment System disproportionately affect safety-net practices? *JAMA Health Forum*. 2020;1(5):e200452. doi: 10.1001/jamahealthforum.2020.0452.

⁸¹ Berenson RA, Shartzer A, Pham HH. Beyond demonstrations: Implementing a primary care hybrid payment model in Medicare. *Health Affairs Scholar*, 1(2). August 2023. <https://doi.org/10.1093/haschl/qxad024>.

⁸² Dinh CT, Linn KA, Isidro U, Emanuel EJ, Volpp KG, Bond AM, Caldarella K, Troxel AB, Zhu J, Yang L, Matloubieh SE, Drye E, Bernheim S, Lee EO, Mugiishi M, Endo KT, Yoshimoto J, Yuen I, Okamura S, Tom J, Navathe AS. Changes in Outpatient Imaging Utilization and Spending Under a New Population-Based Primary Care Payment Model. *J Am Coll Radiology*. 2020 Jan;17(1 Pt B):101–109. doi: 10.1016/j.jacr.2019.08.013.

⁸³ Fusco N, Sils B, Graff JS, et al. Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systematic literature review. *Journal of Managed Care & Specialty Pharmacy* 2023 29:1, 4–16.

sistance to help ensure their unmet medical needs and nutrition needs are met; transportation services to make sure they can attend medical appointments; and support managing chronic health conditions.⁸⁴

Behavioral economics serve to provide insight within developing effective incentives for physicians to deliver high-value care, through structured incentives with thoughtful design; several principles of behavioral economics, such as inertia, loss aversion, choice overload, and relative social ranking can be applied to physician incentive programs.⁸⁵

Question. In Tennessee, our hospital emergency department staff grapple with the fourth highest rate of ED utilization in the country. It shouldn't be this way. For seniors on Medicare and for all Tennesseans, we know an ounce of prevention is worth a pound of care. A 2022 report by AAFP's Robert Graham Center and Primary Care Collaborative provides evidence that access to a usual source of care is associated with fewer ED visits and more preventive services.

What are your recommendations for reforming Medicare payment to connect every Tennessee senior to primary care and prevention—giving our EDs some relief and ultimately improving patient health while reducing costs?

Answer. A natural place to start is to invest more in primary care, empowering PCPs to act as the “quarterback” or “point guard” of a patient's care team. Robust primary care has consistently demonstrated an improvement in population health and reduction in health disparities.⁸⁶ Despite this, the United States systemically underinvests in primary care. Expenditure on primary care in the U.S. has declined over the past decade, ranging from 6.2 percent in 2013 to 4.6 percent in 2020 across all insurance types. Medicare spends an estimated 4 percent of its total spending on primary care,^{87, 88, 89} about \$15 billion per year, which is half that of many other developed countries.⁹⁰ In contrast, we spend more on inpatient care and hospitalizations than other nations. Within the U.S., primary care is systematically underinvested relative to other specialties,^{91, 92} despite the fact that PCPs play the most central role in a patient's health and face the cognitively and logistically complex task of care coordination and integration. Procedural specialties are compensated significantly more than primary care and other office-based specialties.^{93, 94, 95} Changing fee schedule weights alone will not fix this; studies demonstrated that a recent upweighting of reimbursement for office visits led to only a 2-percent de-

⁸⁴ CMS, Medicare Advantage Value-Based Insurance Design Model. <https://www.cms.gov/priorities/innovation/innovation-models/vbid>.

⁸⁵ Emanuel EJ, Ubel UA, Kessler JB, et al. Using Behavioral Economics to Design Physician Incentives That Deliver High-Value Care. *Annals of Internal Medicine*, November 2015. <https://doi.org/10.7326/M15-1330>.

⁸⁶ Jabbarpour Y, Petterson S, Jetty A, Byun H, Robert Graham Center. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. *Milbank Quarterly*. 2023 Feb. https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf.

⁸⁷ New “Scorecard” Finds Primary Care Funding and Physician Workforce Are Shrinking. AA of Family Physicians. February 24, 2023. <https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/primary-care-scorecard.html>.

⁸⁸ Jabbarpour Y, Petterson S, Jetty A, Byun H, Robert Graham Center. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. *Milbank Quarterly*. 2023 Feb. https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf.

⁸⁹ Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Intern Med*. 2019 Jul 1;179(7):977–980. doi: 10.1001/jamainternmed.2018.8747.

⁹⁰ OECD Country Health Profiles, 2023. <https://www.oecd.org/els/health-systems/primary-care.htm>.

⁹¹ Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Intern Med*. 2019;179(7):977–980. doi:10.1001/jamainternmed.2018.8747v.

⁹² Zuckerman S, Merrell K, Berenson RA, Cafarella Lallemand N, and Sunshine J. 2015. Realign Physician Payment Incentives in Medicare to Achieve Payment Equity Among Specialties, Expand the Supply of Primary Care Physicians, and Improve the Value of Care for Beneficiaries. Washington, DC: Urban Institute, Social & Scientific Systems Inc.

⁹³ Hsiao WC, Braun P, Yntema D, Becker ER. Estimating Physicians' Work for a Resource-Based Relative-Value Scale. *N Engl J Med*. 1988; 319:835–41.

⁹⁴ Katz S, Melmed G. How Relative Value Units Undervalue the Cognitive Physician Visit: A Focus on Inflammatory Bowel Disease. *Gastroenterol Hepatol (NY)*. 2016 Apr;12(4):240–4.

⁹⁵ Bodenheimer T, Berenson RA, Rudolf P. The Primary Care-Specialty Income Gap: Why It Matters. *Ann Intern Med*. 2007 Feb 20;146(4):301–6. doi: 10.7326/0003-4819-146-4-200702200-00011.

crease in the Medicare payment gap between primary care and specialty physicians (from a gap of \$40,259.80 to one of \$39,434.70).⁹⁶

Beyond mobilizing more dollars into primary care, we need to enable PCPs to invest in new capabilities and grant them more flexibility. One potential path would be to provide PCPs with consistent per-beneficiary per-month (PBPM) payments in addition to certain fee-for-service payments.⁹⁷ These PBPM payments would be designed to cover the estimated 25 percent of PCP activities that are not currently captured in the Medicare Physician Fee Schedule, such as care coordination, communication with other providers, addressing social determinants of health, and improving patient and caregiver health literacy. This would balance the goals of preserving access through FFS payments while enabling PCPs to practice more patient-centered, rather than visit-centered, care. Ultimately, it would unshackle PCPs from a system that tries to capture every activity across thousands of codes. PBPM payments enable PCPs to invest in sustainable practice infrastructure transformation such as hiring case managers and care coordinators or integrating technology and team-based care. This care model redesign is of particular importance for improving the health of patients with multiple chronic conditions while reducing wasteful administrative complexity.

Hybrid primary care payments cannot be implemented at scale without congressional action. The Centers for Medicare and Medicaid Services (CMS) have conducted several demonstration projects implementing hybrid payments (*e.g.*, Comprehensive Primary Care Plus). It also has the authority to—and should—implement hybrid payments in the Medicare Shared Savings Program (MSSP),⁹⁸ the largest accountable care program in Medicare. However, moving past demonstrations to impact Medicare beneficiaries nationwide will require Congressional action to grant CMS the appropriate authority.

The evidence for hybrid payments is promising. Blue Cross Blue Shield of Hawaii, or Hawaii Medical Services Association (HMSA), has conducted what is perhaps the most rigorous test of hybrid payments for primary care to date in its Population-based Payments for Primary Care (3PC) model. The 3PC model is a hybrid model that shifted the majority of payments to PCPs to a risk-adjusted per-member per-month payment, while continuing to pay some services as FFS; underlining a value-based payment (VBP) approach and its proven success. Continued VBP can incentivize additional investment in primary care.

PREPARED STATEMENT OF PATRICIA L. TURNER, M.D., MBA, FACS, EXECUTIVE
DIRECTOR AND CHIEF EXECUTIVE OFFICER, AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons (ACS) thanks the Senate Finance Committee for convening a hearing on the challenges of the Medicare physician payment system. The ACS remains committed to improving the care for all surgical patients, including those living with chronic conditions, and to ensuring that Medicare beneficiaries receive the highest quality of care. We appreciate the opportunity to describe some of the recent work the ACS has undertaken in improving surgical quality and value. We hope to continue partnering with Congress on potential reforms to the current system to ensure that improving care and access for the surgical patient stays at the forefront.

The ACS and our more than 90,000 members recognize the impact that chronic conditions can have on surgical patient outcomes. These conditions have a distinct impact on the finances of Federal health programs and create additional challenges for providing high-quality care. In the United States, more than 130 million adults suffer from at least one chronic condition.¹ These patients often require additional preparations or more intensive post-acute care after surgery is performed. ACS is

⁹⁶ Neprash HT, Golberstein E, Ganguli I, Chernew ME. Association of Evaluation and Management Payment Policy Changes with Medicare Payment to Physicians by Specialty. *JAMA*. 2023;329(8):662–669. doi:10.1001/jama.2023.0879.

⁹⁷ Berenson RA, Shartz A, Pham HH. Beyond demonstrations: Implementing a primary care hybrid payment model in Medicare. *Health Affairs Scholar*. 2023 Aug;1(2):qxad024.

⁹⁸ Commonwealth Fund. Response to Request for Information on HHS Initiative to Strengthen Primary Health Care from the Office of the Assistant Secretary for Health, Department of Health and Human Services. https://www.commonwealthfund.org/sites/default/files/2022-08/TO%20ATTACH%20AS%20DOWNLOAD_Commonwealth%20Fund_OASH%20Primary%20Care%20RFI_7.29.22.pdf.

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5876976/>.

focused on improving the quality of care provided and achieving the optimal outcome for all our patients.

Our surgeon members have firsthand experience with the challenges posed by the lack of an inflationary update and more recently the continued reductions to fee-for-service Medicare payments. Centers for Medicare and Medicaid Services (CMS) policies have resulted in broad and arbitrary cuts. These reductions are often the unintended consequence of statutory budget neutrality requirements for the Physician Fee Schedule. One aspect of budget neutrality falls on the Medicare Physician Fee Schedule conversion factor. These conversion factor reductions create a strain on physicians working towards value-based care and fail to incentivize quality or care coordination. This results in the Medicare program taking resources away from certain physician specialties in order to finance priorities in other areas. A payment model designed in such a way that different specialties are pitted against one another is counterproductive, since all specialties are doing their best to provide quality care to their patients with ever-scarcer resources. Since 2001, physicians have seen their Medicare physician payments decrease by 13 percent in real terms between 2001 and 2024 before indexing for inflation. In addition to these cuts, the impact of inflation has raised the overall cost to provide care as costs for rent, equipment, staffing and utilities have increased. Surgeons and other physicians have also seen an increase in financial pressures to meet new bureaucratic barriers such as increased use of prior authorization in Medicare Advantage.

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), ACS has made significant investments to translate what we have learned about improving quality of care and outcomes into proposals to increase value for surgical patients. Our efforts have included:

- The submission and approval of one of the first Advanced Alternative Payment Model (APM) proposals to the MACRA-enacted Physician-Focused Payment Model Technical Advisory Committee, or PTAC, which is the “first stop” for adoption of a stakeholder-developed APM;
- Ongoing work to increase transparency in pricing through standardization of episode definitions; and
- Proposing novel quality measures that incentivize evidence-based, team-based care organized around the geriatric hospital patient.

Yet today, many physicians still struggle with the same barriers to improving outcomes and transitioning to modern payment systems that they did a decade ago:

- Surgeons are faced with a Medicare Physician Fee Schedule (PFS) conversion factor for 2024 that remains below the 1998 level;²
- The combination of inflation and a lack of Physician Fee Schedule updates to account for the increasing cost of providing care means that it costs more to deliver care while payments are declining;
- Most physicians in fee-for-service (FFS) are still evaluated based on measures that do not assess care delivered to their patients or the conditions they treat, meaning no information is available for improvement efforts or for patients and referring physicians to make care choices; and
- Surgeons wishing to move beyond FFS will find few physician-focused alternative payment models are available for them, since none of the models submitted to the PTAC have been tested as proposed.

To create stability in the Medicare physician payment system, Congress should immediately address cuts already expected in 2025. A foundational step necessary to maintain access and improve quality for patients is the implementation of positive annual updates reflecting the inflation in practice costs. Under current law, and assuming no additional cuts result from budget neutrality or other policy decisions, it would take decades for the PFS conversion factor 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. Clearly this is not tenable.

STABILIZING MEDICARE PHYSICIAN PAYMENT

The ACS is committed to working together with Congress to ensure the stability of the Medicare PFS through both short- and long-term policy improvements. The Medicare PFS suffers from multiple shortcomings that have negatively impacted the care provided to our patients. It is unique in its lack of a meaningful mechanism to account for inflation and is currently in a multiyear window until 2026 where

²<https://www.ama-assn.org/system/files/cf-history.pdf>.

any positive updates to physician payment must be legislated. Once the positive updates begin in 2026, current law only provides a 0.25-percent conversion factor update for non-APM participants and a 0.75-percent update for qualified Advanced APM participants, still failing to adequately offset the effects of inflation and account for rising medical and staff costs. Without congressional action, continued cuts will challenge physicians to provide adequate services and high-quality care. Additionally, without an annual update for the PFS, it is unlikely that future payments will keep pace with medical cost inflation. This concerning combination of high inflation and a lack of any update for expenses results in a need to deliver expected high-quality care while payments are rapidly declining.

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 positive adjustment only partially offsets the 3.37-percent cut that went into effect in early 2024, and further cuts are expected in 2025. These yearly compounding cuts, combined with a broad lack of viable alternative payment models for surgeons, demonstrate that the Medicare payment system is broken and falling short of the goals of MACRA. **As a starting point to create a more stable foundation for value-based care initiatives, ACS supports building an update into the Medicare Physician Fee Schedule, comparable to other Medicare payment programs, to account for the effects of inflation on the cost of providing care to seniors.** This inflationary update should be separate and distinct from incentives for quality and from the budget-neutral Merit-based Incentive Payment System (MIPS) incentives.

The impact of the lack of inflationary adjustments is further compounded by the overly strict nature of the budget-neutrality trigger. The budget-neutrality requirement in a system with no inflationary updates results in across-the-board cuts for any changes to the PFS expected to increase expenditure by as little as \$20 million annually. This trigger amount has remained the same since its implementation in 1992. Updating the trigger for budget-neutrality adjustments would help to ensure that comparatively minor changes to relative values or the addition of limited new service codes do not always require across the board cuts. **Congress, at a minimum, should amend 42 U.S.C. 1395w-4(c)(2)(B)(ii) to increase the current \$20-million budget-neutrality adjustment trigger and index it for inflation going forward.**

Adjusting the budget-neutrality trigger is an example of a small, but important, concrete step Congress could take to improve the functioning of the current system. Without meaningful 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. Beyond this, it will be necessary to counteract the effects of inflation to help provide stability while Congress and the administration provide support to facilitate the transition to value-based payment models.

The ACS supports building a more modern and equitable care environment for patients, rewarding value and innovation. Addressing well-documented health disparities and ensuring the availability of high-quality care across all settings are imperative, and medicine should be moving steadily toward a system that truly rewards the value of care provided rather than data entry that may not be relevant to the patients treated. This could partially be achieved through testing and expansion of alternative payment models developed by and for specialists. These models should complement primary care focused models, not compete with them, and could include primary care physicians and other specialists focused on chronic conditions in the fiscal attribution model and rewards to encourage care coordination. **Congress should encourage innovation by incentivizing the testing and implementation of physician-developed, value-based payment models. Models developed by subject matter experts such as specialty societies will be better structured to provide and utilize timely, actionable data and allow physicians to improve care.**

FACILITATING THE TRANSITION VALUE-BASED CARE

The ACS believes that medicine should be moving steadily toward a system that truly rewards the value of care provided. APMs can facilitate better care and could also be used to incentivize physicians to practice in rural or underserved areas. Unfortunately, efforts at implementing an Advanced APM were hindered by a breakdown of the process envisioned in MACRA. Along with dozens of other groups, ACS developed and submitted proposals that were reviewed, revised, and evaluated by the PTAC. Fourteen proposals have been recommended for testing or implementa-

tion by the PTAC, but CMS has not tested a single model through the Center for Medicare and Medicaid Innovation (CMMI or Innovation Center) as proposed. This bottleneck has created a disincentive for stakeholder investment into the development of APMs, as witnessed by the lack of new proposals on the PTAC website since 2020.

The ACS-Brandeis Advanced APM proposal included shared accountability for cost and quality for defined episodes of surgical care and allowed for the entire care team, including the primary care physician, to work together toward shared goals. Information on the comprehensiveness of a quality program, along with comparable information on the price of that care, are prerequisites for a valid depiction of the value of care. The ACS has supported the development of standardized episode definitions to foster alignment of both price and quality measurement and create shared accountability for the team of providers. Our proposal would provide the data and incentives necessary to drive value improvement in specialty care. While it is our impression that Congress has provided the resources to CMS and the Innovation Center that are necessary to stand up and test PTAC recommended APMs, there is nothing within the law to compel CMS to try out new programs. This creates further barriers to those seeking to move to value-based care. **Congress should require that at a minimum, some portion of the CMS Innovation Center's budget be dedicated to testing physician and specialist-developed APMs recommended by the PTAC.**

IMPROVING MACRA TO ENSURE MEANINGFUL QUALITY MEASUREMENT AND REDUCE REPORTING BURDEN

The ACS sees quality as a comprehensive program built around the patient, and inclusive of the entire team involved in providing care for patients with a given condition or diagnosis. The current model of individual, disconnected measures is insufficient to achieve coordinated, patient-centered, high-value care and provides little actionable information for physician improvement or patient decision-making when it is time to seek care. This is especially true in rural and underresourced areas where regional shortages in surgeons and other care providers can lead to reduced access and fewer choices for care.

Most physicians in the current FFS system are currently evaluated on measures that do not reflect the care they deliver to patients or the conditions they treat. Further, the payment update associated with the reported data applies 2 years after the data has been reported. This means that no actionable, recent information is available for improvement or to help patients choose the best care for them. In contrast, ACS has designed quality programs to overcome barriers faced by surgeons and other physicians who want to work together to coordinate and improve care. Based on these efforts and the more than 100-year history of ACS working to improve the quality and value of care for surgical patients, the ACS believes addressing the shortcomings of traditional Medicare FFS payments will require new types of quality measures, facilitated by increased flexibility in the facility-based scoring option in MIPS. As described below, such a combination will improve care coordination and reduce surgical complications.

The ACS believes that surgical patients deserve to have the right structures, processes, and personnel in place to provide optimal care and that information should be available to allow them to find and access such care. **Verification programs like the Quality Verification Program (QVP) or the Geriatric Surgery Verification program (GSV) could be used as the basis of programmatic measures that more accurately assess the ability of a system to provide high-quality care to patients.** Programmatic quality measures do the following: align multiple structure, process, and outcome measures; target condition- or population-specific care; apply to multiple quality domains; address the continuum of care; and create actionable information for care teams and patients.

Our experience with programmatic measures exhibits applicability to diverse care settings, limited burden on care providers, and demonstrably better results. Applied correctly, programmatic measures will address the quality gaps created by the current measures.

In early 2023, the ACS submitted a programmatic measure, the Age Friendly Hospital Measure, to the CMS Measures Under Consideration (MUC) list to demonstrate how programmatic measures could be implemented in CMS programs. We are optimistic this measure will be included in the Fiscal Year 2025 Inpatient Prospective Payment System (IPPS) proposed rule and will hopefully be available for hospital reporting in future years. This measure considers the full program of care

needed for geriatric patients. It incentivizes hospitals to take a holistic approach to the provision of care for older adults by implementing multiple data-driven modifications to the entire clinical care pathway spanning the emergency department, the operating room, the inpatient units, and beyond. The measure puts an emphasis on the importance of defining patient (and caregiver) goals, not only from the immediate treatment decision, but also for long-term health and functional status. The measure underscores the importance of aligning care with what the patient values. It acknowledges certain processes, outcomes, and structures that are necessary for providing high-quality, holistic care for older adults across five domains:

- **Domain 1: Eliciting Patient Health-care Goals:** This domain focuses on obtaining patient's health-related goals and treatment preferences to inform shared decision-making and goal concordant care.
- **Domain 2: Responsible Medication Management:** This domain aims to optimize medication management through monitoring of the pharmacological record for drugs that may be considered inappropriate in older adults due to increased risk of harm.
- **Domain 3: Frailty Screening and Intervention (*i.e.* Mobility, Mentation, and Malnutrition):** This domain aims to screen patients for geriatric issues related to frailty including cognitive impairment/delirium, physical function/mobility, and malnutrition for the purpose of early detection and intervention where appropriate.
- **Domain 4: Social Vulnerability (social isolation, economic insecurity, ageism, limited access to health care, caregiver stress, elder abuse):** This domain seeks to ensure that hospitals recognize the importance of social vulnerability screening of older adults and have systems in place to ensure that social issues are identified and addressed as part of the care plan.
- **Domain 5: Age Friendly Care Leadership:** This domain seeks to ensure consistent quality of care for older adults through the identification of an age friendly champion and/or interprofessional committee tasked with ensuring compliance with all components of the measure.

If adopted and implemented, the Age Friendly Hospital Measure could be further enhanced through an expansion of the facility-based scoring option of the Quality Payment Program to make the same measure directly applicable to physicians. Facility-based scoring opportunities are currently limited to very specific circumstances. This scoring method should be expanded to cover more physicians, more facility settings and reporting programs, and to apply it to all four Merit-based Incentive Payment System (MIPS) categories (to include Promoting Interoperability and Improvement Activities, in addition to Quality and Cost as currently in statute). In such a scenario, the score would be determined automatically unless physicians prefer to submit additional data and be scored through a different scoring option. Then, like in other cases, they would have the option of reporting data of their choice.

The ACS developed programs like GSV and QVP have demonstrated marked improvements in patient care in trauma, cancer, bariatric surgery, geriatric surgery, and other areas all of which involve the clinical team and facilities coming together to improve the delivery of care. Alignment with facility reporting is critical for care centering the patient. **We believe a voluntary expansion of facility-based scoring to additional physicians, sites of service, and to all MIPS categories could greatly reduce reporting burden while creating the environment necessary for meaningful quality programs to be recognized and incentivized in the payment environment.**

SURGICAL QUALITY AND IMPACT ON CHRONIC CARE

The ACS recognizes the impact of chronic conditions on both surgical patient outcomes and the finances of Federal health programs. Chronic conditions also have a huge impact on the quality of life of patients and in many cases, surgeons are best positioned to intervene to fix longstanding problems. Patients with chronic, comorbid conditions often face additional challenges in surgery and may need additional preparation or more intensive post-acute care after surgery. ACS's Strong for Surgery initiative provides checklists, tools, and resources that can be used to ensure patients are controlling blood sugar, managing medications, and stopping tobacco use to reduce the risk of adverse events and improve outcomes from surgery. Additionally, surgical procedures often play a role in the prevention of chronic condition progression or can even serve as curative treatment of some chronic conditions. Surgical intervention to address chronic conditions comes in many forms and continues to grow with the introduction of innovative technologies and procedures, such as groundbreaking work in the area of xenotransplantation, which will help save

even more lives in the future and overcome shortages of viable donor organs for transplantation. Curative interventions include orthopaedic surgery for chronic joint pain, transplantation for organ failure, and bariatric surgery, which can be an effective treatment for obesity, diabetes, hypertension, and osteoarthritis. Reducing obesity can further treat or prevent other conditions such as cancer etc.³

Even the effects of a traumatic injury can be considered a chronic condition, and surgeons play a key role in helping those affected emerge from trauma and re-enter normal life, both through surgical skill to address the immediate injury, and by being part of a team-based approach to managing the injury from stabilization through rehabilitation. Simply put, surgery lets people get back to work and live fuller, more productive lives. ACS is focused on improving the quality of surgical care for all patients and avoiding or managing chronic conditions is an important aspect of this.

Quality has been the cornerstone of the American College of Surgeons since its founding more than a century ago. Through the Power of Quality campaign, ACS is on a mission to improve surgical quality and patient care for every patient and in every setting across the country. This includes expanding the reach of ACS Quality Programs to more hospitals, enlisting more surgeons in quality improvement efforts, encouraging adoption of quality metrics into public policy, and expanding patient recognition of the important role these programs play in health care. At the ACS, we believe a strong, united voice for surgery is essential to effective advocacy in service of our patient and surgeon community. With 13 ACS Quality Programs, the ACS has set the standard for high quality, evidence-based surgical care and is the definitive marking of quality patients should seek.

Achieving optimal outcomes for the surgical patient must include a highly qualified surgeon and must involve an entire well-functioning team. This focus on team-based care includes coordination with primary care physicians and other specialists to ensure that the patient's chronic conditions are managed to help patients achieve the best possible outcomes. This commitment to team-based care is witnessed by our verification programs, which include standards related to disease management. For example, the ACS Surgical Quality Verification Program or QVP includes a standard on "Disease-Based Management Programs and Integrated Practice Units." The purpose of this standard is to ensure that the surgical management of diseases, procedures, and patient populations requiring multispecialty care is integrated, organized, and standardized. Another standard on team-based processes in the five phases of surgical care requires facilities to document processes to optimize patients for surgery through review of medications and glycemic controls and processes to ensure continuity of care postoperatively. The standard also looks specifically at the unique needs of geriatric patients, including management of prescriptions for multiple chronic conditions frequently found in this population. ACS recognizes hospitals that successfully meet these standards through our Power of Quality campaign.

This focus is not new and was also demonstrated in the ACS-Brandeis Advanced APM, where the entire care team including primary care and other specialists managing chronic conditions could participate to improve value. Unfortunately, the model was never advanced by CMS. Team-based APMs with patient-focused measurement represent an opportunity to both improve patient outcomes and lower costs for Medicare through increased efficiency.

CONGRESSIONAL ACTION IS NEEDED TO REFORM MEDICARE PAYMENT: IN SUMMARY

The value transformation is underway but could greatly benefit and accelerate through a combination of improving the foundation of the Physician Fee Schedule and efficient investments in the partnership between CMS and stakeholders interested in improving the way quality is measured and incentivized. Congress has the power to provide CMS with direction, flexibility, and additional authority to help achieve the goal of improving value. ACS proposes the following specific action items for Congress to consider:

- **First, prevent pending cuts and implement an update mechanism in the Physician Fee Schedule to account for inflation. This will create a stable base from which physicians can make the leap to models involving risk;**

³<https://asmbs.org/for-patients/explore-conditions-procedures/>.

- **Eliminate the Medicare PFS budget-neutrality requirement or increase the trigger threshold from \$20 million to \$100 million and index it annually to account for inflation;**
- **Expressly direct that, at a minimum, a portion of the Innovation Center's budget be devoted to testing APMs recommended by the PTAC; and**
- **Expand facility-based scoring in MIPS to accommodate the type of collaborative measure proposed by ACS. This should include expanding the program to additional settings such as hospital outpatient departments and ambulatory surgical centers.**

These are relatively modest reform ideas that would stabilize the Physician Fee Schedule and build upon MACRA to squarely focus on providing high-value care to our patients. Surgeons are devoted to being part of the solution and to continue to work with Congress to advance these critical and necessary reforms. The ACS thanks you for convening this important hearing and for the committee's attention to improving quality and value, particularly for those with chronic conditions. We share this commitment and look forward to working collaboratively with the committee to achieve the goal of safe, affordable care for all Americans.

QUESTIONS SUBMITTED FOR THE RECORD TO PATRICIA L. TURNER, M.D., MBA, FACS

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. As you noted in your testimony and responses during the hearing, numerous features of the Physician Fee Schedule, as currently structured, have resulted in volatility and uncertainty for clinicians. Broad utilization overestimates for certain new billing codes, for instance, have triggered draconian conversion factor (CF) reductions across all specialties and subspecialties, and policy changes aimed at ensuring appropriate reimbursement for certain subgroups of clinicians necessitate, under budget-neutrality rules, sizable payment cuts for others, with no countervailing enhancements for the latter groups.

What specific legislative steps should Congress consider taking in order to provide long-term stability and sustainability for the PFS, beyond modifying the current CF update schedule?

Answer. First, the American College of Surgeons urges Congress to correct the unique problem of a lack of a meaningful inflation adjustment by implementing an annual update to account for increases in the cost of providing care to seniors. The rampant inflationary pressure in recent years has exacerbated the underlying problem and has damaged physicians' ability to continue to provide the high-quality care expected by Medicare beneficiaries in a timely manner. The cost of staff salaries, rent, technology upgrades, medical supplies and other resources have continued to rise while the per-unit reimbursement to physicians has not kept pace and has decreased. This is problematic in and of itself, but the effect is compounded by how payments are set across the health-care system. Facilities incur many of the same costs as physician practices with similar inflation dynamics, particularly when it comes to labor costs. But because facilities receive inflationary adjustments, it becomes a severely distorted employment market for the same staff and labor where facilities receive money from Medicare to hire staff in recognition of inflation while physician practices do not. This places a greater burden on physician practices than on all other providers, making this problem a unique Medicare Physician Fee Schedule problem that requires a unique Medicare Physician Fee Schedule solution. At a minimum, an annual inflationary index to mitigate these increases in costs should be adopted.

Beyond modifications to the update schedule, ACS also believes that it is time to adjust the estimated change in spending that triggers a budget-neutrality adjustment. Under current statute, when there is an increase annually of \$20 million to the fee schedule, it automatically requires CMS to implement across-the-board cuts for physicians. This dollar amount is not indexed for inflation and has not been updated since implementation of the fee schedule in 1992. Increasing this amount to \$100 million and indexing it for inflation moving forward would help to increase stability in Medicare physician payment by eliminating the need for cuts when necessary but minor changes are implemented to the fee schedule.

Question. In the absence of these types of steps, what concrete impacts will current and future beneficiaries most likely experience?

Answer. If Congress does not take the steps necessary to ensure long-term stability, there will be several damaging developments to those providing and receiving care. Due to the increasing financial strain faced by self-employed physicians, many of whom are less able to make up for the insufficient Medicare payment updates there will be an increased likelihood of more providers selling their practices or possibly even leaving the practice of medicine. Not only will this lead to increased consolidation in health care, but it will also create gaps in access, particularly in underserved and rural communities.

Another foreseeable consequence of failure to stabilize physician payments will be to further delay the needed transition to value-based care and alternative payment models (APMs). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was designed to create a “period of stability” during which new models and measures would be created. Unfortunately, due to the lack of regular updates and the budget-neutral nature of the PFS, this period of stability was punctuated by a series of cuts to many physicians. Some of these cuts were delayed or reversed, but not all. This has created an uncertain playing field where it is difficult to make the investments necessary in care models and technology for the value transformation to be successful. Furthermore, the expected physician developed models and quality measures have not materialized, further harming efforts to modernize and improve care models.

Question. Regulations finalized earlier this year aim to streamline and standardize prior authorization standards and requirements in certain contexts, but the final rule expressly excludes outpatient medications, whether administered by clinicians or dispensed to beneficiaries via pharmacy. Both the American College of Surgeons (ACS) and the American Academy of Family Physicians (AAFP) made note of this omission in comments submitted in response to the proposed rule.

Specifically, ACS “urge[d] CMS to apply its proposed policies to all drugs covered by any of the impacted payers to align PA processes and related implementation efforts with those for all other covered items and services.” Similarly, AAFP expressed concern and disappointment that “these proposals do not apply to prior authorizations for prescription and outpatient drugs,” and went on to “strongly [urge] CMS to expand the proposals in this rule to Medicare Part D plans and prescription drug coverage across other impacted payers.”

Virtually all clinician organizations concurred with these recommendations, including those focused on treating some of the most onerous chronic conditions, such as cancer. The Community Oncology Alliance, for instance, asserted, “Addressing the drug treatment for a person’s cancer should clearly be part of any effective, comprehensive regulatory initiative to streamline the current onerous prior authorization processes.” Patient advocates uniformly agreed with these concerns, which a number of groups have cited as a key source of delays and denials of potentially lifesaving therapeutics, across both the provider-administered setting and the retail pharmacy context.

Studies have found that physician-administered drugs and biologics account for a large and growing share of all forms of prior authorization and utilization management (UM) under Medicare Advantage (MA) plans’ medical benefits, and the application of various UM tools, such as prior authorization, step therapy, and formulary exclusion, has risen dramatically in recent years under Medicare Part D plans. Analysts broadly project that these trends will accelerate, rather than reverse, in the midst of Part D’s benefit redesign.

What specific components should Congress, or CMS, consider including in any effort to streamline and otherwise reform requirements and standards for UM tool application to outpatient drugs (both physician-administered and pharmacy-dispensed)?

Answer. First and foremost, ACS would urge that it be made clear that PA should never be required for maintenance drugs that patients have been on for an extended period of time as part of an evidence-based form treatment plan for their chronic condition or conditions. Such requirements, including for periodic prior authorization for insulin for a diabetic patient, add significant burden on the care team and create the potential for harmful disruptions in needed medications for patients while providing no measurable benefit in the quality and appropriateness of care.

Question. What benefits would these components offer to patients and clinicians?

Answer. Reducing unnecessary burdens would have far-reaching benefits for patients and their physicians including reduced stress and potentially better adherence to treatment plans as unnecessary disruptions in care could be avoided.

Question. In the absence of reform efforts along these lines for medications, what prior authorization and UM burdens and other effects will clinicians and beneficiaries continue to experience, even after CMS's final rule takes effect?

Answer. ACS believes that PA adds little value in most cases while adding substantial cost and burden. PA requirements should be limited to instances where a clear need can be demonstrated. As highlighted by the question, these concerns also extend beyond PA to other forms of UM, including step therapy, nonmedical switching, and restrictive formularies.

Question. On a number of fronts, CMS has leveraged subregulatory guidance as a means of clarifying current-law and regulatory requirements for plans, providers, and beneficiaries. In the context of Part D, 42 CFR 423.272(b)(2) establishes regulatory requirements for plan designs, noting that the agency will not approve a bid if "the design of the plan and its benefits (including any formulary and tiered formulary structure) or its utilization management program are likely to substantially discourage enrollment by certain Part D eligible individuals under the plan." Notably, clause (iii) specifies that even if a plan adheres to proper category/class inclusion requirements, such a plan may still fall short of this standard by virtue of its exclusion of certain drugs.

Patients, providers, and plans, however, have flagged uncertainty as to the scope and practical implications of this language. Updates to the regulations themselves, or else to the relevant sections of the Medicare Prescription Drug Manual, could present a potential avenue for clarifications, along with exemplary examples of compliant and noncompliant formulary design and UM tool applications.

What types of clarifications or examples, in this context, could CMS provide, either through guidance or regulations, to ensure adequate and efficient medication access for Part D enrollees, many of whom take multiple prescriptions for chronic diseases?

Answer. The ACS has previously submitted comments to CMS detailing our concerns with the use of utilization management tools in Part D that have the potential of disrupting the patient-physician relationship and overruling physician judgment in terms of which treatment is best for a patient. Physicians prescribe drugs based on clinical judgment, patient needs, and evidence-based medicine—not on profit incentives.

One specific area where we have expressed concern would be the use of step therapy requirements on immunosuppressive drugs, which are often prescribed for transplant patients. The ACS believes that any perceived savings that might be achieved by expanding utilization management to these drugs would be far outweighed by the potential harm both to patients and the Medicare program should changes to coverage for immunosuppressants lead to unnecessary hospitalizations, organ rejection, or other serious health consequences.

Question. In some cases, formularies exclude or disadvantage lower-cost alternatives to branded medications with higher list prices while charging beneficiaries coinsurance tied to said inflated sticker-price figures. The Part D statute directs pharmacy and therapeutic (P&T) committees to "base clinical decisions on the strength of scientific evidence and standards of practice," but it remains unclear to what extent these committees or the Part D plans themselves factor cost sharing, UM hurdles, or lower-priced alternatives (and the role of rebates) in making these types of determinations.

How does cost-sharing burden affect medication adherence and clinical outcomes for patients, and how should plans (and their P&T committees) incorporate these types of considerations into their recommendation and review processes?

Answer. Medication adherence before and after surgery is important in ensuring optimal outcomes. Excessive cost sharing can have an adverse effect on patients being able to afford their medications and therefore on adherence. As noted previously with the immunosuppressive example above, this can have the opposite effect, costing more rather than less while also having dire consequences for patients and their health.

Question. What formulary review mechanisms or reporting requirements could CMS implement in order to ensure effective and meaningful oversight of formulary design, UM tool application, and the clinical basis for these decisions?

Answer. As mentioned above, ACS strongly maintains that physicians should be able to use their clinical judgment in prescribing the most appropriate medication for their patient. Expanding UM for drugs can have adverse effects on patient care. One specific area where we have expressed concern would be the use of step therapy requirements on immunosuppressive drugs, which are often prescribed for transplant patients. The ACS believes that any perceived savings that might be achieved by expanding utilization management to these drugs would be far outweighed by the potential harm both to patients and the Medicare program should changes to coverage for immunosuppressants lead to unnecessary hospitalizations, organ rejection, or other serious health consequences. If CMS implements UM, these requirements should be made clear to the prescriber in real time.

Question. Artificial intelligence (AI) has the potential to mitigate administrative burden and enhance health-care quality, including in the context of Medicare. That said, some clinicians have raised concerns around the program's inability to keep pace with AI-enabled tool development through its coverage and payment policies, undercutting access, especially for smaller practices.

What use cases for AI-enabled tools and technologies seem most promising in the context of clinician care?

Answer. One promising case for AI-enabled tools would be the potential application towards reducing the administrative burden that many providers face. This could range from typical administrative tasks, insurance related correspondence, record maintenance, and even note taking while consulting with a patient. Generative AI has the potential to greatly increase the overall productivity of providers and create a more efficient health-care sector for our patients. This could lead to providers having more time and energy to focus on improving and developing the highest possible quality of care. AI tools should always be used to aid physicians in their decision-making, not to replace them, as regardless of the sophistication of the algorithm used, they still lack physician judgment and training.

Question. What steps should CMS and Congress take to ensure adequate coverage and reimbursement for appropriate AI-enabled tools in this context?

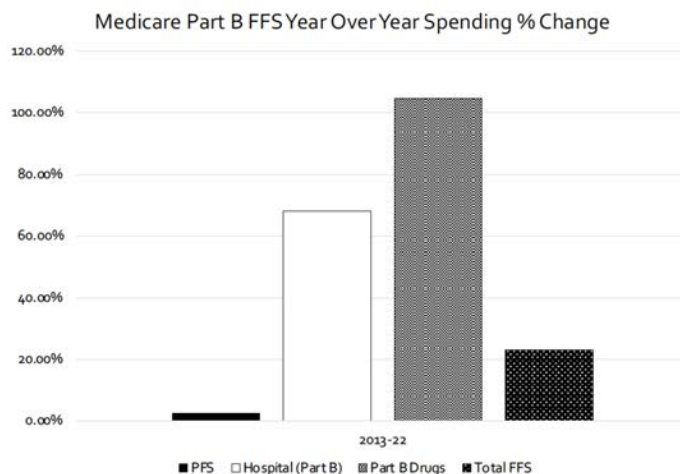
Answer. CMS should ensure that approved AI-enabled tools receive coverage commensurate with the value that they provide to patients, and reflective of the costs associated with acquiring, implementing, and updating the tools as well as any costs associated with integrating such tools into electronic health records (EHRs).

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. According to the Medicare Payment Advisory Commission (MedPAC), Medicare's Physician Fee Schedule updates have grown more slowly than input cost growth in recent years. Yet Medicare spending on an annual basis is up 30 percent over 5 years and the Congressional Budget Office (CBO) just revised Medicare spending for benefits—for this year and last year—up another \$272 billion. MedPAC explains this is due to an increase in the volume and intensity of Medicare services.

Can you explain the root cause for higher Medicare spending while at the same time, physicians are receiving less in reimbursement?

Answer. There are numerous factors that account for the increased Medicare spending. As you point out, Medicare spending is up 30 percent over 5 years. Over that period an additional 2 million Americans have entered the program, and CPI increased by approximately 23 percent. When these factors are taken into account this increase seems more reasonable. Over that same period, updates to the Physician Fee Schedule have actually been a net negative. Virtually all the growth in overall Part B spending can be accounted for due to increased spending on facilities and prescription drugs. The following table, created from data in the *2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, shows the growth in Part B spending from 2013 to 2022 was driven largely by spending in hospital outpatient services and Part B drugs and virtually none of the growth is attributable to physician services (from Table IV.B6.—Aggregate Part B Reimbursement Amounts on an Incurred Basis).



QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. Adjusted for inflation in practice costs, the American Medical Association estimates that Medicare physician payments plummeted by 29 percent from 2001 to 2024. As one of the only provider groups without an automatic inflation-based update to their Medicare payments, physicians are falling farther and farther behind. Medicare physician payments and their impact on patient access to care is a major issue for my constituents.

As a gastroenterologist in Vancouver, WA told me, it's become increasingly hard for physicians to maintain their practices because the costs of labor, equipment, and technology have spiked while Medicare payments have remained largely stagnant. One radiologist in Seattle told me that her income has effectively stayed the same for her entire career, despite inflation and other changes, because of flat Medicare reimbursements. A rehab therapy provider in Anacortes, WA said that unless physicians get relief, her practice and others like it might have to close.

Nonpartisan government stakeholders are recognizing the damaging impact these cumulative payment cuts have on patient access to care. Multiple Medicare trustee reports have stated that access to Medicare-participating physicians will become a significant issue in the long term.

This access is especially important for people with chronic conditions. Care for chronic diseases is expensive: the CDC estimates that spending on individuals with chronic disease accounts for about 90 percent of all health-care spending in the U.S. Providers caring for Medicare patients take on a disproportionate amount of that burden because older adults have a higher risk of living with or developing chronic conditions. A 2022 study found that 66 percent of people aged 65 and older have at least two common chronic conditions. That means that Medicare physician payment relief is directly tied to ensuring that chronic care patients can access the care they need.

What impact does the financial instability from low Medicare payments have on access to care for patients with chronic diseases?

Answer. If Congress does not take the steps necessary to ensure long-term stability there will be several damaging developments to those providing and receiving care. This includes the more than 130 million adults that suffer from at least one chronic condition. These patients often require additional preparations or more intensive post-acute care once the surgery is performed. If long-term stability to the Medicare payment system is not achieved there would be several impacts to chronic care patients. One immediate impact would be the increased barrier to care. Pro-

viders that can no longer keep their lights on would either opt out of Medicare or worse would close their office. Either situation would be increasingly damaging, especially to those in underserved areas or care deserts. In other circumstances, the practices might fight to continue providing care but be forced into ownership models that increase negative consolidation in the market or lead to ownership of health-care providers by nonhealth-care entities.

Question. A recent MedPAC report to Congress recommends that Congress increase the 2025 Medicare physician payment rate above current law with an inflation-based payment update because physician practices cannot absorb the increasing costs to practice medicine. Do you agree that this policy would help with inadequate reimbursements?

Answer. Yes, the American College of Surgeons strongly believes that the implementation of an inflationary index would help to strengthen and stabilize the Medicare payment system. Without some acknowledgement of the adverse impact of inflation on a physician's ability to care for patients, we will continue to struggle to adapt to the need to do more with less, jeopardizing our ability to provide the highest quality care to American seniors. However, unlike the MedPAC recommendation, the American College of Surgeons believes the Medicare Physician Fee Schedule should be updated by a full inflationary update factor (and not half of the Medicare Economic Index (MEI) as put forward by MedPAC).

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. As part of the Merit-based Incentive Payment System (MIPS), physicians must be compliant in promoting interoperability as part of their reimbursement, which helps to facilitate the sharing of data between various providers.

I have long been an advocate for health IT initiatives that can improve efficiencies and reduce costs in the health-care system, and I believe that sharing information between providers through an interoperable network has immense upside, so long as there are safeguards to protect patient privacy and ensure taxpayer funds are spent appropriately.

However, there continue to be challenges to physicians meeting interoperability metrics, like information blocking for example in which an individual or entity impedes the delivery or utilization of an electronic health record, making interoperability impossible.

In your view, how have practices been impacted by information blocking?

Answer. Based on feedback from our surgeon members, surgical practice has been less impacted by information blocking and more from the lack of comprehensive interoperable data standards to allow for easy repurposing of clinical data to aid in clinical decision-making at the point of care. Further, the sometimes-excessive cost of updating or upgrading EHR products to meet certification requirements is burdensome and at times prohibitive, especially for small or rural practices.

Question. Are you aware of instances in which the timeliness or quality of the care physicians are able to provide patients has been impacted by a limited ability or complete inability to access electronic health records?

Answer. While the flow of clinical data is far from effortless, and interoperability and lack of easy access to clinical data remain at times problematic for care coordination efforts and long term tracking of patients journeys, our surgeon Fellows express greater concern at the delays in care created by unnecessary prior authorization requirements.

Question. Furthermore, beyond information blocking, what other challenges persist in physicians accessing patients' health information electronically despite the billions of dollars spent to implement electronic health IT and interoperability?

Answer. The substantial investment in HIT was well meaning and important, but as noted, has struggled to meet its full promise. From the outset, the focus on specific technology rather than on the standardization and use of data to inform and improve clinical care has limited the benefit to patients.

Question. In your testimony, you allude to the issue of Congress being consistently relied upon to take certain action to address payment adjustments to the Physician Fee Schedule.

As you continue to advocate for more stability to the Physician Fee Schedule to ensure providers have the certainty they need to continue providing high-quality care to their patients, in addition to ensuring the fee schedule accounts for the impacts of inflation, could you expand on a few other policies referenced in your testimony that you believe Congress should consider that could also result in greater stability for providers through the fee schedule?

Answer. There are several steps that Congress can take to ensure the long-term stability of Medicare physician payments. First, Congress should prevent any future cuts and implement a mechanism into the Physician Fee Schedule to account for inflation. Eliminating across-the-board cuts, not intended to incentivize higher-quality care, as well as implementing a regular update mechanism are critical first steps in creating a stable FFS payment system. This stability is a prerequisite for physicians to be able to evaluate and invest in value-based payment models involving financial risk.

Second, Congress should eliminate the Medicare PFS budget-neutrality threshold requirement or increase the trigger from \$20 million to \$100 million annually and index it for inflation moving forward. This will help ensure that small but necessary corrections to the relative values of services will not necessarily result in harmful cuts for others.

Regarding the transition to value-based care, ACS strongly believes that any changes to existing FFS payment programs should ensure that they are designed to help further this goal. That is, they should provide patients and their physicians with the data on quality and price necessary to make decisions based on value as well as for efforts to improve outcomes and efficiency. One example of a change that would further this goal would be to expand the facility-based scoring option in MIPS to accommodate measures explicitly designed to foster team-based coordinated care. ACS has developed a geriatric surgery focused measure called the Age Friendly Hospital measure, which is included in the FY 2025 IPPS proposed rule.

Furthermore, to ensure that physicians have options when they decide to make the leap to advanced APMs, Congress should specify that a portion of the CMS Innovation Center's budget be devoted to testing advanced alternative payment models (APMs) developed by physicians and evaluated by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Question. Another issue you touch on in your testimony pertains to the frustrations that the Physician Fee Schedule today does not adequately reflect the quality of care that physicians provide due to certain shortcomings in existing evaluation metrics and data lags.

To address this, you suggest that new quality measures need to be built into fee-for-service payments.

Could you outline for the committee what some of those quality measures are and how you think implementation of them could, in practice, improve the quality of care that is provided to patients?

Answer. The ACS has a more than 110-year history of measuring and improving the quality for the surgical patient. Over that time, we have come to recognize the importance of shared goals and evaluation in spurring quality improvement. We have also used this knowledge to develop a number of quality programs aimed at verifying that the people, resources, structures, and processes necessary for optimal outcomes are in place. Recently, the ACS, in collaboration with the American College of Emergency Physicians and the Institute for Healthcare Improvement, developed a programmatic measure that builds on the successes of the ACS Geriatric Surgery Verification Program and incentivizes hospitals to take a holistic approach to care delivery for older adults. The measure highlights the importance of implementing a clinical framework, using evidence-based best practices, which provides goal-centered, clinically effective care for older patients.

The Age Friendly Hospital Measure is a "focused-composite" metric that comprises a handful of structural metrics (such as staffing and roles specific to geriatrics), process metrics (such as frailty assessments and delirium screening), and outcomes focused on activities that are essential for effective care in this demographic. If finalized, the measure would be a positive step toward incentivizing team-based care organized around the geriatric patient.

As noted previously, expanding the facility-based scoring method in MIPS and specifically allowing care teams to be scored on measures such as this would go a long way toward improving physician quality measurement in surgery.

QUESTION SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. Your testimonies and discussions at the hearing noted that the Merit-based Incentive Payment System (MIPS) is cumbersome for clinicians. The intention of MIPS is to foster performance improvements, leading to better outcomes for patients. You all mentioned that MIPS is burdensome and may not accurately capture the quality of care physicians provide.

Are there policy proposals that could be implemented to make MIPS more accurate and less burdensome?

Answer. Any time that a physician is asked to report on something that is not perceived as important to improving patient care it will be perceived as burdensome, and this is the case with many of the requirements in MIPS. As passed, it appeared that MIPS would be developed as an on-ramp to value-based payment, with funding for new quality measures to fill in caps and a pathway for creation of APMs. Unfortunately, MIPS has proven in many ways to be more of a reshuffling of the deck than a transformation, with little progress in developing and moving to more meaningful measures and no progress in testing or implementing physician developed APMs. Recent proposals to reform the program seem to promise more of the same, with the MIPS Value Pathway (MVP) proposal being built from the same pieces. ACS has previously proposed and submitted an Advanced APM and worked with CMS to explain how we would make a more meaningful MVP for surgery. Unfortunately, CMS lacks the authority and/or the will to implement novel approaches.

Within the current MIPS framework, ACS would support implementing and expansion of the facility-based scoring method in conjunction with new programmatic quality measures. An example of a programmatic measure is the Age Friendly Hospital measure developed by ACS, in collaboration with the American College of Emergency Physicians and the Institute for Healthcare Improvement. This measure builds on the successes of the ACS Geriatric Surgery Verification Program and incentivizes hospitals to take a holistic approach to care delivery for older adults. The measure highlights the importance of implementing a clinical framework, using evidence-based best practices, which provides goal-centered, clinically effective care for older patients.

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The ACS believes that components of this measure, and of comprehensive verification programs in general, meet many of the goals of the four MIPS categories and that facility-based scoring should be expanded beyond quality and cost to include Promoting Interoperability and Improvement Activities, and that the program should be expanded to other facility types. Such measures show great promise in bringing the entire care team together to center the patient.

QUESTION SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. I am working on a bill to relieve providers excelling in the Medicare Shared Savings Program (MSSP), from prior authorization (PA) requirements in MA. The bill rewards providers in Accountable Care Organizations (ACOs) that generate savings for Medicare by granting an exemption from PA requirements for their MA beneficiaries. If an insurer believes there is a rationale for maintaining PA in such instances, this bill would require them to seek prior approval from the Centers for Medicare and Medicaid Services (CMS). I would welcome your thoughts and comments on this idea.

Answer. While the ACS would want to review legislative text of such a proposal prior to taking a position, we do see a certain logic in waiving PA requirements for health systems that have demonstrated appropriateness and adherence to best practices through achievement of savings to the Medicare program. By achieving savings to the program, physicians have shown that they are not inappropriately or excessively utilizing care. In addition to savings, the ACS would caution that such an exemption should also require that quality benchmarks are attained to show that patient outcomes are not adversely affected in efforts to achieve shared savings. Achieving the patients’ goals of care and optimal outcomes should be our ultimate

objective. Whether or not savings are achieved, PA requirements should not be allowed to get between physicians and patients as they strive for this goal. The ACS would welcome the opportunity to review and comment on this legislative proposal when it becomes available.

QUESTIONS SUBMITTED BY HON. MARSHA BLACKBURN

Question. CMS has a track record of overestimating spending associated with payment policy changes. For example, in 2013, the introduction of Transitional Care Management codes led to a reduction of over \$700 million in fee schedule payments. This was due to the agency projecting utilization of around 5.6 million claims, whereas actual claims fell below 300,000 in the first year.

A similar scenario unfolded with Chronic Care Management codes. CMS made budget-neutrality adjustments based on an assumed utilization of 4.7 million claims, yet actual claim volume totaled less than 1 million. These assumptions, among others, perpetually reduce the aggregate dollars available under the fee schedule, with no mechanism for reconciling overestimates or underestimates.

Do you believe the Physician Fee Schedule should incorporate forecast error adjustments to rectify over- and underestimations exceeding a certain threshold through subsequent payment modifications?

Answer. Lacking information on how frequently forecasting errors occur and how often they are overestimates versus underestimates, the ACS has not taken a formal position on this proposal. However, it is important to take steps to ensure that cost and utilization estimates are as accurate as possible. While reversing cuts due to overestimates of utilization would be beneficial, the ACS also does not believe that it makes sense to penalize all providers through budget-neutrality adjustments in the first place. If small but necessary adjustments are made to the Physician Fee Schedule these changes should not require patients with other care needs to sacrifice access or quality of care due to unjustified cuts.

Question. Medicare physician pay and its impact on patient access to care remains a significant issue for my constituents. Adjusted for inflation in practice costs, Medicare physician pay plummeted 29 percent from 2001 to 2024. Although Congress did act in the March 8th government funding package to reduce the 3.37-percent cut that went into effect on January 1, 2024, by an additional 1.68 percent, the 29-percent reduction in Medicare payments over the last 2 decades is reflective of this most recent congressional action. Plus, physicians are now set up for another steep payment cut at the end of this year. Nonpartisan government stakeholders recognize the damaging impact these cumulative payment cuts have on patient access to care. Multiple Medicare trustee reports stated that “absent a change in the delivery system or level of update by subsequent legislation, the trustees expect access to Medicare-participating physicians to become a significant issue in the long term.”

Can you discuss some of the impacts of this pressing financial instability on physician practices, including consolidation, difficulty retaining staff, and trouble keeping their doors open amid rising costs?

Answer. As with any business, independent physicians must have enough income and revenue to pay for rent, utilities, and staff as well as their own income. In addition, physicians must spend an increasing amount of time and money in meeting burdensome mandates both from the government and private insurers, including an increasing amount of time spent dealing with prior authorization and other utilization restricting techniques that interfere in the patient-physician relationship. The impact of higher-than-average inflation in recent years has contributed greatly to the overall cost to provide care as costs to staff these facilities continue to increase year after year. Lacking any mechanism within the PFS to account for these increases, they contribute to a growing financial strain that may force them to make difficult decisions related to staff retention, patient access or even whether or not to remain in private practice. These decisions may be even more difficult in rural areas, where it is difficult for physicians to increase volume to make up for decreasing payments. Loss of a practice in a rural area may jeopardize access to care for patients without other reasonable alternatives. Further, physician practices are often hiring staff in direct competition with hospitals and other facilities. When physician practices are not compensated for inflationary increases, but hospitals and other facilities are, the ability to recruit and retain physician practice staff becomes untenable.

Question. What available mechanisms do Congress and HHS have within current statutory authority to help provide adequate Medicare payments to physicians and ensure continued patient access to care? For example, alleviating the administrative burden on practices through reforms to the Merit-based Incentive Payment System?

Answer. The Merit-based Incentive Payment System (MIPS) as implemented falls far short of the goals of tying payment more closely to quality and value, while creating the potential for significant additional burden or even steep payment reductions, particularly for those in small, independent practices.

Most surgeons currently evaluated in MIPS are employed by a health system or large group practice that reports measures on their behalf, many of which may be completely unrelated to the care they provide. Physicians in such employment situations are statistically more likely to score well in MIPS even though the measures reported add little to improve patient care.

Smaller independent practices on the other hand would face the full burden of reporting on quality, promoting interoperability, and improvement activities. While the measures they select are likely to be more meaningful, the burden is also higher and many may choose not to fully report or not to participate at all, calculating that the cost of compliance is greater than the reduction mandated.

The ACS believes that the burden on physicians could be greatly alleviated by an expansion of the facility-based scoring option. Currently, facility-based scoring only applies to quality and cost and only measures in very specific circumstances. In order to incentivize team-based care and greater coordination of effort toward shared goals, this option could be expanded to a larger array of physician specialties and to all four categories of the MIPS program. While some of these changes would require legislative authority, we think they are worthwhile improvements that would reduce burden and improve patient experience and outcomes.

Question. Do these cuts disproportionately impact access to care in underserved areas?

Answer. Cuts to the Medicare physician payment system have led to increased instability for physicians that aim to provide high-quality care in underserved communities. While finding adequate care in these areas can already present a challenge, stagnation in Medicare payments has led to an even larger burden. Many of these providers are the only care in the area. When they are forced to close their offices, it can lead to an immense barrier to care. Patients in these communities are then forced to either forgo the care they need or travel immense distances to receive care.

Question. Are there enough APMs approved by CMMI for all physician practices to participate? In other words, are all practices ready to move to value-based care models? If not, what steps can Congress and/or the administration take to promote the value-based care pathway?

Answer. The current options for participation in Advanced APMs are limited to programs developed by CMS, and exclude models proposed and developed by physician experts and approved by the PTAC because CMS never implemented a single one of them. Existing models may be limited in scope, specialty, or geographic location, leaving some physicians without access to a model or with too few eligible patients to meet participation thresholds. The ACS continues to advocate for a portion of the CMMI budget to be dedicated to testing physician stakeholder-developed models approved by the PTAC to expand the options available to physicians.

Question. Do you think the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has an important role to play in the creation of new APMs? Do you know why CMMI to date has not accepted any of the PTAC-approved models?

Answer. ACS in conjunction with Brandeis University developed and submitted proposals that were reviewed, revised, and evaluated by the PTAC. We found the process of revising and improving the proposal in response to PTAC questions and evaluation helpful and in the end our proposal was recommended for limited scale testing. In total, at least 14 proposals have been recommended for testing or implementation by the PTAC, but CMS has not tested a single model through the CMMI as proposed. This bottleneck has created a glaring disincentive for stakeholder investment, as witnessed by the lack of new proposals on the PTAC website since 2020. While ACS does believe that there is a role for PTAC to play, unfortunately there is no current law to compel action from CMS once proposals have been reviewed and recommended. Congress should require that at a minimum, some portion of the CMS Innovation Center's budget be dedicated to testing physician- and specialist-developed APMs recommended by the PTAC.

Question. Every year, we see an alarming decline in physicians offering essential care services. This trend is partly fueled by soaring costs for practices, already high yet constantly increasing administrative burden, and low reimbursement rates, often well below the cost of providing care.

How has the cost of providing lifesaving care changed over the years for your practice, and how has the payment for those services caught up or not caught up?

Answer. Unfortunately, the cost of providing care has continued to rise through several factors while the level of compensation has been a consistent target to offset other costs. Our surgeon members have firsthand experience of the financial challenges posed by the lack of an inflationary update as costs for rent, equipment, staffing, and utilities have increased. On top of this, surgeons have faced payment reductions due to the budget neutrality threshold requirement in the MPFS. These conversion factor reductions create a strain on physicians working towards value-based care and fail to incentivize quality or care coordination. This results in the Medicare program taking resources away from certain physician specialties in order to finance priorities in other areas. A payment model designed in such a way that different specialties are pitted against one another is counterproductive, since all specialties are doing their best to provide quality care to their patients with ever-scarcer resources. Since 2001, physicians have seen their Medicare physician payments decrease by 13 percent in real terms before indexing for inflation.

Question. How does the yearly scramble to delay or reduce CMS payment cuts to the PFS impact your ability to plan for the future? What would it mean for you and practices like you if these cuts were fully implemented and not scaled back?

Answer. These reoccurring cuts make it incredibly difficult for providers and physicians to take a long-term approach and improve the care they deliver. Due to the ambiguity in payments, it has led to a yearly source of frustration for physicians that still own and operate their own practices. While we appreciate Congress stepping in to mitigate the cuts, the annual and ongoing uncertainty of whether physicians will see relief makes it extremely difficult to operate a business. If this trend of yearly cuts continues more often than not, privately owned small business providers will continue to either close their doors or refuse to accept new Medicare patients. The impact this would have on our health-care system and the lifesaving care that is performed would be detrimental for patients in these communities.

Question. As a value-based purchasing program, MIPS was supposed to reward physicians who achieved quality and cost-efficient care. However, for years physicians have raised concerns about the program, including that it increases administrative burden and does not accurately capture quality.

What has been your experience with MIPS and the administrative burden that it entails?

Answer. The ACS experience with MIPS has been punctuated by missed opportunities. As envisioned, MIPS would have provided an on-ramp to value-based payment models through development of novel quality metrics, greater reliance on clinical data from registries and other improvements. However, most of the important reforms were lost in implementation and the experience of many surgeons has been one of increased administrative burden, quality measures nonreflective of the care they provide, stagnant or falling reimbursement and lack of meaningful data for quality improvement in patient care.

Question. Is it time to consider replacing the program with a more valuable alternative? If so, what are some of the program's benefits that should be considered when designing its replacement?

Answer. CMS has sought to address some of the shortcomings of the MIPS program through implementation of MIPS Value Pathways or MVPs. When this was first announced, ACS envisioned what we thought a surgical MVP should look like. Based on the more than 110 years of experience in measuring surgical quality, ACS has developed a number of quality programs in both broad and targeted areas of surgery. If ACS were to develop a surgical MVP, the core of the payment model would be based on evidence-based verification programs that assure that all of the resources, structures, processes, and personnel necessary for optimal outcomes are present. Such a model would build in the use of digital clinical information, improvement efforts, and patient experience and outcomes, meeting the key requirements of MIPS. While the requirements of such a program would be as intensive or perhaps even further reaching than the current program, we believe that they

would be less burdensome because each component of the program is explicitly designed to improve care to the patient and ensure their safety.

If Congress considers reforms to MIPS, it is critical to address the core shortcomings with the current FFS payment system. Chief among these shortcomings are its lack of a regular payment update mechanism to create a stable environment, as well as its current failure to create an onramp toward more integrated payment models centered on the patient.

Question. Part of the Physician Fee Schedule's MIPS program measures interoperability, which is impeded by information blocking by providers, vendors, or others wanting to hoard patient data, which can affect MIPS performance and reduce reimbursement to providers.

How have your practices been impacted by information blocking?

Answer. Surgical practice has been less impacted by information blocking and more from the lack of comprehensive interoperable data standards to allow for easy repurposing of clinical data to aid in clinical decision making at the point of care. Further, the sometimes excessive cost of updating or upgrading EHR products to meet certification requirements is also at times burdensome.

Question. Have you had experiences where your ability (or inability) to access health records has impacted the timeliness or quality of the care you are able to provide your patients?

Answer. All physicians have experienced at least minor delays when working with clinical patient data and lack of easy access to clinical data remains at times problematic for care coordination efforts and long-term tracking of patients' journeys. However, our fellows express greater concern at the delays in care created by unnecessary prior authorization requirements, which can consume immense amounts of time and staff resources while adding no clinical benefit.

Question. Do existing Federal quality and payment incentive programs under Medicare, like Promoting Interoperability under the Merit-based Incentive Payment System, enable up-to-date, consolidated longitudinal health records accessible without special effort?

Answer. Both the Medicare program and private health plans still have a long way to go to achieve the full promise of EHRs and health data. Having timely access to current and complete health data for the patient in standardized data elements fit for use by multiple purposes such as risk calculators, EHRs, registries, clinical decision tools, health monitoring devices, and so forth would go a long way toward improving care for patients.

Question. With over \$40 billion spent and nearly 2 decades of effort put into implementing electronic health information technology, fax machines remain widely used for sharing health data in our health-care system.

Why is this the case, and what challenges persist in accessing patients' health information electronically?

Answer. At the time of the initial passage of the HITECH Act much of the country's medical records were still solely in paper form. While the Federal investments have gone a long way toward shifting the arena of medicine into the digital age, progress has not been uniform, and interoperability challenges still remain. Though the use of legacy technologies is waning, they still do occur both provider-to-provider and provider-to-insurer communications. ACS believes that much of the problem is attributable to the early focus on the use of specific technologies rather than on the standardization of data elements and the use of the clinical data, which was the ultimate goal.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

This morning the Finance Committee gathers to discuss how to update and strengthen Medicare's guarantee of high-quality health benefits for the next generation of America's seniors.

Colleagues, I want to be clear from the outset: traditional Medicare is falling behind when it comes to helping seniors manage their health when they are living with multiple chronic conditions.

I know members of the committee are interested in reforms to the way physicians and nonphysician practitioners are paid. In my view, any update to the way physicians are paid by traditional Medicare must provide a lifeline to the tens of millions of seniors who live with chronic conditions and who are struggling to coordinate their health care in a fragmented health system that's not putting their health first. This hearing is going to jump-start that debate.

The Finance Committee delivered a wake-up call to America in 2018 when we passed our first round of reforms to care for chronic conditions in Medicare, under the chairmanship of Orrin Hatch, who graciously agreed to partner with me, along with Senators Warner and Isakson. Together, we sounded the alarm that Medicare is no longer only an acute care program. Medicare spending today is dominated by chronic conditions. Often, chronic conditions cluster together in ways that complicate health and require specific, ongoing management by a physician.

Cardiovascular conditions like high blood pressure and high cholesterol most often occur with diabetes, for example. If you add conditions like cancer and COPD to the equation, seniors and their doctors are left with a crazy quilt of appointments, prescriptions, and care plans that lead to confusion and worse health care. When a senior's health gets this complicated, care coordination is not optional.

Recent events have underlined the growing cost of chronic disease in America. Even before the COVID-19 pandemic, life expectancy began to dip in the United States from a 2014 peak of 79 years old. The pandemic led to a backlog of preventive care that may only accelerate chronic illness in the U.S.

The way traditional Medicare pays physicians to manage and treat these conditions has not kept up with the times. Democrats and Republicans were right to tackle the problem in 2018, and it's now time to act boldly again.

In contrast to traditional Medicare, in the past decade Medicare Advantage plans have been given a host of tools to incorporate chronic disease management into their plan choices. That's because MA was built from the ground up to offer more flexible benefits to give seniors the option to choose a Medicare plan that was tailored to their needs. Plans are able to use rebates—growing from \$12 billion in 2014 to \$67 billion in 2024—to support these flexibilities and extra benefits.

Unfortunately, it's increasingly clear that insurance companies are more interested in playing coding games with Medicare's payment rules to maximize their bottom line. Medicare Advantage plans seem to be using more and more of these excess dollars to juice their marketing and enrollment. Experts told this committee that MA plans spend \$6 billion per year on marketing middlemen who sell their plans to seniors.

Just last week, the Centers for Medicare and Medicaid Services announced it is cracking down on insurance middlemen selling seniors' personal information over and over again, resulting in a blizzard of phone calls and high-pressure marketing campaigns during enrollment season.

This time around, I want to make sure that traditional Medicare is keeping up with the needs of beneficiaries when it comes to care coordination, nonmedical determinants of health, and the like. That could include steps such as reducing or eliminating cost sharing for care coordination services. Seniors shouldn't have to pick up the tab when their primary care doctor works with their cardiologist or physical therapist to coordinate a care plan for high blood pressure.

It also means empowering primary care. Physicians and other providers who deliver primary care are on the front lines when it comes to helping seniors manage their chronic illnesses. But as everybody in this room knows, there is a persistent shortage of primary care providers in many parts of the country. That's partially a result of out-of-whack payment rules that make primary care a less appealing specialty than other fields. Primary care providers need to be valued and compensated more fully by Medicare—as they are put in the driver's seat alongside seniors to help navigate their health needs.

In my view, the challenge before the Finance Committee is to improve the way Medicare pays for services delivered in the doctor's office, or at home, so there is a laser focus on managing those chronic conditions that are dominating the health of seniors.

The Finance Committee has had a lot of success over the last decade getting new policies in this area into black-letter law on a bipartisan basis, but there's still more to be done. I'm looking forward to hearing from our witnesses and getting to work on the next steps.

COMMUNICATIONS

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The Alliance for Home Dialysis (the Alliance) appreciates the Senate Finance Committee's focus on ensuring high-quality care for Medicare beneficiaries with chronic conditions. Our organization focuses on the chronic conditions of chronic kidney disease (CKD) and End Stage Kidney Disease (ESKD) with a focus on dialysis treatment choice. We believe that these conditions should be of particular interest to this Committee not only because of the burden to patients, but also because all ESKD patients, regardless of age, are eligible for Medicare.

As background, the Alliance is a coalition of kidney disease stakeholders including patients, clinicians, dialysis facilities, other providers, and industry who came together starting in 2012 to advocate for policies that would increase access to and uptake of home dialysis in the United States.

Improving the uptake of home dialysis matters for clinical and quality-of-life reasons. Research shows that both home dialysis modalities (peritoneal dialysis and home hemodialysis) offer quality-of-life and clinical advantages—and patients deserve access to these benefits. For example, home hemodialysis allows for tailoring the dialysis prescription to allow for more frequent or longer-lasting sessions. Such more frequent sessions can result in faster recovery and fewer side effects,¹ improved cardiac status,² improved survival rates,³ and increased rehabilitation opportunities.⁴ Peritoneal dialysis patients also experience fewer side effects and have fewer dietary restrictions than in-center dialysis patients.⁵ Both home modalities also offer significant quality-of-life advantages like ease of scheduling, ability to continue to work, ability to travel, and reduced dependence on transportation to dialysis clinics.

While home dialysis has been growing in recent years, in large part due to government and provider commitment to ensuring patients have access to all modalities, it still only hovers at a little over 13% of patients doing their treatments at home. This is striking given that the Government Accountability Office (GAO) shared in 2015 that they believe up to 25% of patients could be successful on home dialysis.⁶ Furthermore, a few years ago, HHS set a far loftier goal that 80% of new ESKD patients should be receiving dialysis at home or be transplanted by 2025. While we have seen increases in uptake of home dialysis in recent years, additional policy changes, including through legislation, are needed to ensure that patients can access

¹Heidenheim AP, Muirhead N, Moist L et al. Patient Quality of Life on Quotidian Hemodialysis. *Am J Kidney Dis*. 2003 Jul; 42(1 Suppl):36–41.

²Culleton, B et al. Effect of Frequent NHD vs. CHD on Left Ventricular Mass and Quality of Life. *JAMA* 2007;11

³Foley, R.N., D.T. Gilbertson et al. Long interdialytic interval and mortality among patients receiving hemodialysis. *New England Journal of Medicine*. 2011 365, no.12:1099–1107.

⁴Blagg, Christopher. "It's Time to Look at Home Hemodialysis in a New Light." *Hemodialysis Horizons: Patient Safety & Approaches to Reducing Errors*. (2006): 22–28. Web. 12 Apr 2012. <https://www.aami.org/docs/defaultsource/uploadedfiles/filedownloads/horizons/home-blagg.pdf>.

⁵"A Brief Overview of Peritoneal Dialysis." DaVita, Inc., Web. 16 Jul 2012. <https://www.davita.com/treatment-services/peritonealdialysis/living-well-on-pd>.

⁶Government Accountability Office. (2015). *End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis*. (GAO Publication No. 16–125). Washington, D.C.: U.S. Government Printing Office.

these important treatments and increase the overall number of patients on home dialysis in the U.S.

We appreciate all Congress has done thus far to increase access to home dialysis. Congress has been particularly impactful with regard to policy changes in telehealth; the Bipartisan Budget Act of 2018⁷ included key elements of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017 (the CHRONIC Act), including a provision that allowed home to be the originating site for a telehealth visit. In practice, this means that patients can now see their doctors for the monthly capitated payment visit from the comfort of their homes, avoiding often lengthy travel to and from the dialysis facility. Allowing this expanded access to telehealth makes home dialysis more accessible for patients and has helped increase uptake to these important therapies. Policy changes like this are key to ensuring expansion of home dialysis.

Congress has a key role in ensuring patients have choices when faced with decisions about treating their ESKD through dialysis. Specifically, Kidney Disease Education (KDE) is a policy area where the Committee could advance policy changes to positively impact the lives of patients and ensure that they have choices in their treatment. We strongly believe this policy area merits the Committee's further attention.

Medicare's current KDE benefit provides up to 6 sessions of educational services for individuals with Stage 4 chronic kidney disease. KDE covers a wide range of topics, including how to take care of your kidneys, how to manage other chronic diseases that often come alongside CKD, diet, medications, and treatment options for both dialysis and transplant.

Unfortunately, KDE is extremely underutilized with only about 2% of eligible patients taking advantage of the benefit. We believe, and the Government Accountability Office (GAO) has stated as well, that the expansion of KDE could lead to the expansion of home dialysis.⁸ The Alliance urges the Senate Finance Committee to consider the following legislative policy options for increasing access to KDE:

1. Congress should permit reimbursement for stages 3b and 5 CKD patients to receive the KDE benefit.

Currently, KDE is only permitted for patients with stage 4 CKD. The Alliance believes that reimbursement for such services should be allowed for patients with stage 3b and 5 CKD.

Stage 3b CKD means moderate to severe loss of kidney function, with kidneys working somewhere between 30–44% of what the average healthy kidneys do.⁹ In addition, health risks get higher at this stage of CKD, including the risk of developing co-occurring heart disease or high blood pressure and the stage of CKD progressing to stage 4. There is also a higher risk of complications at this stage of CKD, like anemia, bone disorders, and metabolic acidosis, which is a buildup of certain acids in the blood. Patients with CKD stage 3 are likely to need dialysis services at some point, though their disease may take some time to develop. They deserve to be educated in the same manner as patients with stage 4 CKD.

Stage 5 CKD actually refers to the first phase of ESKD, or kidney failure; these patients have kidneys that are working less than 15% of what the average healthy kidneys can do.¹⁰ Patients at stage 5 have the highest risk for comorbidities like heart disease and the CKD complications discussed above. They may also have symptoms of kidney failure like urinating less or not at all, itchy skin, feeling tired, trouble concentrating, numbness, achy muscles. Shortness of breath, nausea, loss of appetite, trouble sleeping, and foul-smelling breath. These patients require immediate dialysis or a transplant to survive; they must be educated about their options, but they are currently not allowed KDE.

Based on these realities about stages 3b and 5, we strongly believe that KDE should be allowed for both and ask the Committee to consider this change.

⁷ Bipartisan Budget Act of 2018. Public Law 115–123. 2018. <https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf>.

⁸ See citation 1.

⁹ Stage 3b Chronic Kidney Disease. National Kidney Foundation. <https://www.kidney.org/atoz/content/stage-3b-chronic-kidney-disease-ckd#about-stage-3b-ckd>. Accessed 11 April 2024.

¹⁰ Stage 5 Chronic Kidney Disease. National Kidney Foundation. <https://www.kidney.org/atoz/content/stage-5-chronic-kidney-disease-ckd#:~:text=Stage%205%20CKD%20means%20you,or%20they%20are%20on%20dialysis>. Accessed 11 April 2024.

2. Congress should expand the providers qualified to provide KDE beyond doctors, physician assistants, nurse practitioners, and clinical nurse specialists.

Under current law, only *qualified persons* can provide kidney disease education services, which are defined as certain healthcare entities for which payment can be made under the Physician Fee Schedule, including physicians, physician assistants, nurse practitioners, and clinical nurse specialists, or hospitals, Critical Access Hospitals, skilled nursing facilities, home health agencies, or hospices in a rural area. Notably, this excludes home dialysis nurses, who are arguably some of the most knowledgeable professionals about kidney disease. The Alliance urges the Committee to consider expanding who can provide KDE to include home dialysis nurses.

In addition, current law does not allow dialysis facilities to provide KDE. We believe that dialysis facilities are an appropriate place for KDE services to occur and that they should be allowed to bill for KDE—with appropriate guardrails. In our view, these guardrails should seek to avoid so-called “patient steering” to one facility over another. Specifically, we would urge Congress, alongside allowing facilities to bill for KDE, to instruct CMS to enact requirements on what kind of information can be provided to exclude any provider-specific or advertising information. In addition, we recommend that CMS play a role in approving educational materials before they are deployed to patients.

Thank you for your work in ensuring that Americans with chronic conditions have access to the treatments they need. We appreciate your consideration of these requests related to Kidney Disease Education and look forward to continuing to work with you to improve the lives of Americans with CKD and ESKD.

ALLIANCE FOR WOMEN’S HEALTH AND PREVENTION

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April 17, 2024

United States Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510

Dear Senator Wyden, Senator Crapo, and Members of the Senate Committee on Finance,

The Alliance for Women’s Health and Prevention (AWHP) respectfully requests that you prioritize the impact of obesity on America’s seniors as you consider legislative proposals to update and strengthen Medicare service payment and delivery, including providing coverage for anti-obesity medications (AOMs). As an organization focused on women’s preventive health, **AWHP recognizes that obesity is a chronic disease with a significant impact on women, including those with coverage through Medicare.**

Obesity is a chronic, treatable disease that affects more than 3 in 10 women¹ nationwide and has a disproportionate impact² on women of color. It is associated with over 200 other chronic conditions, including many that specifically affect women throughout their lives, such as breast and ovarian cancers as well as fertility issues. Women with obesity are also more likely to face harmful social stigma and discrimination. For instance, women with obesity are less likely³ to be promoted at work, and as many as 69% of women⁴ with obesity face weight bias in healthcare settings. Finally, obesity has a tremendous economic burden, with economic costs (both direct and indirect) totaling \$1.72 trillion in 2018.⁵ Given obesity’s extensive impact, AWHP believes that insurance coverage for the full scope of obesity care options is critical to improving women’s health. Evidence-based obesity care includes coun-

¹ <https://www.kff.org/other/state-indicator/adult-obesity-bysex/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

² <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity>.

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6452122/>.

⁴ <https://www.obesityaction.org/wp-content/uploads/Weight-Bias-in-Healthcare1.pdf>.

⁵ <https://milkeninstitute.org/content-hub/research-and-reports/reports/modernizing-care-obesity-chronic-disease-how-guide-employers>.

selling or intensive behavioral therapy, behavior modification, AOMs, weight loss surgeries, and nutrition services.

Unfortunately, even though obesity has serious consequences, especially for women, it is often misunderstood, leading to health insurance barriers that keep the full range of obesity care options out of reach for many women—particularly AOMs. In fact, just half of U.S. employers currently cover, or are considering covering, the latest generation of AOMs. Only 16 state Medicaid programs⁶ cover AOMs. Notably, Medicare does not cover⁷ AOMs.

Medicare coverage for comprehensive obesity care is critical to ensure that women over 65 living with obesity can access the care they need. **As such, AWHP strongly supports the passage of the Treat and Reduce Obesity Act (TROA), bipartisan legislation that would ensure that Medicare beneficiaries have access to the full scope of obesity care options, including AOMs.** Ensuring that Medicare beneficiaries and the providers who care for them have access to all evidence-based options for treating this disease is only fair. We wouldn't place this type of restriction on care for other chronic diseases like cancer or heart disease. As such, AWHP strongly encourages the Senate Committee on Finance to prioritize this topic in its future discussions on improvements to the Medicare program.

AWHP, along with leading stakeholders from across the healthcare community, recently launched the EveryBODY Covered campaign, a first-of-its-kind initiative aiming to activate women to advocate for insurance coverage of comprehensive obesity care. **We believe that addressing obesity requires a comprehensive approach that includes equitable access to all evidence-based treatments and interventions.** We encourage you to refer to the resources available on our website (<https://everybodycovered.org/>) for more information about obesity's particular impact on women, and we appreciate your attention to addressing obesity and supporting women's health.

Respectfully,

Millicent Gorham, CEO

ALLIANCE OF SPECIALTY MEDICINE
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The Alliance of Specialty Medicine ("Alliance"), a coalition of 16 medical specialty organizations representing more than 100,000 specialty physicians, is deeply committed to improving access to specialty medical care through the advancement of sound health policy. We thank the Committee for convening a hearing to examine how changes to Medicare physician payment can bolster chronic care. Today, we outline suggested actions that Congress should take to stabilize the Medicare physician payment system while ensuring successful value-based care incentives are available for specialty physicians. We continue to have serious concerns about structural challenges and instability in Medicare payments to physicians and request your assistance to begin the process of stabilizing and improving Medicare physician reimbursement and performance programs through legislative reforms.

Our statement addresses the major pain points our specialty organizations and their members have been facing under the current Medicare physician payment system and quality improvement programs. **We urge Congress to take the following actions to address many of the challenges patients and doctors face:**

- Replace flat base payment updates and improve nominal base payment updates (in CY 2026 and beyond) with annual payment updates to the Medicare conversion factor that are based on an appropriate inflationary index that reflects rising practice costs, such as the Medicare Economic Index (MEI).
- Exempt the following from budget-neutrality adjustments:
 - Newly-covered or expanded Medicare benefits, items, and services, such as preventative services and new technologies,
 - Items and services that are delivered in response to a public health emergency (PHE), and,

⁶ <https://files.kff.org/attachment/REPORT-50-State-Medicaid-Budget-Survey-for%20State-Fiscal-Years-2023-and-2024.pdf>.

⁷ <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncid=38&ncdver=3&chapter=all&sortBy=title&bc=18>.

- Changes in relative values due to increased practice costs (*e.g.*, clinical labor, professional liability).
- Authorize the Secretary of Health and Human Services the flexibility to waive or modify budget neutrality requirements in other circumstances, as appropriate.
- Require ongoing and consistent updates of key data inputs used to set Medicare payments to physicians (*e.g.*, practice expense and liability insurance) and hold physicians harmless from these updates, which are outside their control,
- Perform more granular and timely evaluations of the impact of the Quality Payment Program (QPP) and Physician-Focused Payment Model Technical Advisory Committee (PTAC) on health care quality and value, as well as access to care—particularly as it relates to specialty care. While PTAC recently released an environmental scan of value-based payment models,¹ which includes a table listing the percentage of physicians participating in Advanced alternative payment models (APMs) by specialty, it is missing specialties and only reflects trends from 2017–2019. Such outdated information is of little value to our members. Similarly, the QPP Experience Report data set, which provides aggregate participation and performance information related to each year of the Merit-based Incentive Payment System (MIPS), is also outdated. As of April 2024, the most current data set available to the public relates to the 2021 performance year. Given how frequently CMS changes MIPS rules, performance thresholds, and measure sets, CMS' more than two-year lag in reporting participation and performance trends makes it nearly impossible for the public to meaningfully assess the impact of the program and to comment on the feasibility of newly proposed policies. Additionally, the QPP Experience Report data set, which is slightly more current than the recently released PTAC data and includes much more granular, individual clinician-level and specialty-specific data, includes no information about APM participation through the QPP.
- Make technical improvements to MACRA to strengthen the QPP, including:
 - Providing CMS with the authority to truly dismantle the silos that currently prevent more accurate and efficient assessments of value. At the very least, Congress should provide CMS with the authority to make MIPS more streamlined and flexible, allowing physicians to earn credit across the four performance categories of MIPS for certain robust activities, such as reporting to and using data from a clinical data registry to improve care.
 - Providing CMS with the authority to move away from the current one-size-fits-all approach to measurement and permit more flexibility in regard to measure adoption, participation pathways, scoring, and performance thresholds to better reflect the diversity of clinical practice in terms of settings, specialties, and/or patient populations. This should include:
 - Providing CMS with the flexibility to adjust the weights of the MIPS performance categories over time to reflect the current state of the health care landscape, shifting gaps in care, and the availability of relevant measures.
 - Allowing CMS to set the MIPS performance threshold (*i.e.*, the minimum points needed to avoid a penalty) at an appropriate level each year based on performance trends and stakeholder input, rather than setting it at the mean or median score of all MIPS eligible clinicians during a previous performance period, as mandated by MACRA. Given the program's frequently changing policies and unpredictable disruptions to our healthcare system that impact participation and performance scores, CMS should not be locked into using historic averages as a barometer of success.
 - Allowing CMS to set multiple performance thresholds, such as a separate threshold for small and rural practices.
 - Providing CMS with the flexibility to provide MIPS credit for more innovative and comprehensive investments in quality and value, such as ongoing data collection and performance feedback for purposes of Board certification, performance measurement taking place under other CMS programs, and quality and cost analyses under APMs, so long as minimum standards of reliability and validity are met.

¹ <https://aspe.hhs.gov/sites/default/files/documents/6d9f300bb4b45d16485d2a2c013a4151/PTAC-Sep-18-Escan.pdf>.

- Require CMS to better support and encourage the use of specialty-focused Qualified Clinical Data Registries (QCDRs), the development and use of specialty-specific measures, and participation pathways that are more meaningful to specialists.
- Enforce MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with better understanding existing gaps in care and supporting the development of quality and cost measures.
- Allow CMS to modify the MIPS Cost category by:
 - Removing the primary care-based total per capita costs measure mandate that continues to hold physician practices—including specialties that are explicitly excluded from the measure—responsible for costs outside of their control.
 - Removing the requirement that episode-based cost measures account for at least ½ of Part A and B expenditures to ensure prioritization of episodes with high variability and that specialists can directly impact.
 - Requiring that any evaluation of cost also simultaneously account for any changes in quality among the same patient population to ensure cost-containment efforts do not result in poorer quality care or negatively impact access to care.
- Improve the APM pipeline to provide specialists more opportunities to participate meaningfully in APMs and qualify for the APM track of the QPP.
- Restore and extend the full 5% APM incentive payment, which expired following the 2022 performance year/2024 payment year, and maintain current QP thresholds to facilitate specialty physician movement into APMs, including new and more relevant models that have not yet materialized.
- Require CMS to release more granular and timely data regarding physician participation in MIPS, eligibility for the APM track of the QPP, and participation in APMs in general, by specialty.
- Reduce administrative burdens and ensure safe, timely, and affordable access to care for patients by streamlining prior authorization in the Medicare Advantage program.

Physician Payment Instability

Prior to the enactment of MACRA, the costs associated with running a physician practice were on the rise, and the price of medical supplies, equipment, and clinical and administrative labor remain substantial, as demonstrated by the Consumer Price Index (CPI) and MEI (*see* American Medical Association (AMA) Medicare Updates Compared to Inflation (2001–2024)²). Unlike other Medicare providers that receive annual payment updates based on an inflation proxy, such as the CPI, MACRA established physician payments to include flat and nominal base updates in the initial years, transitioning to a system that emphasizes performance-based adjustments. Specifically, from 2016 to 2019, physicians were slated to receive a 0.5% increase in their Medicare payments each year, 0% updates from 2020 to 2025, and based on their participation in the QPP, an update of 0.25% or 0.75% in 2026 and beyond.

Under MACRA, Congress aimed to create a period of stable, albeit not inflation-adjusted, payment levels, so physicians would have a predictable revenue stream while transitioning to more value-based care models, such as MIPS and APMs, which offer additional financial incentives based on the quality and efficiency of care. The first problem was the decision to undermine the onramp to value-based care by decreasing the CY 2019 base update from 0.5% to 0.25%.³ Then as the CMS implementation of MACRA began to unfold (as the chart below shows), in most years since MACRA's implementation, the “budget neutral” MIPS payment incentive failed to close the gap between the change in the Medicare conversion factor and practice costs. While some physicians may have benefitted from additional incentives provided through an “Exceptional Performance Bonus” pool, these bonuses were short-term and expired with the 2022 performance year.

² <https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf>.

³ Sec. 53106 of the Bipartisan Budget Act of 2018, Pub. L. 115–123.

MIPS Payment Year	Budget Neutral MIPS Adjustment ⁴	Change from previous year in Medicare Conversion Factor ⁵	Actual Medicare Economic Index (MEI) ⁶	Impact ⁷
2019	0.29	0.11	1.5	-1.10
2020	0.31	0.14	1.9	-1.45
2021	0.00	-3.3	1.4	-4.70
2022	0.01	-0.80	2.1	-2.89
2023	0.11	-0	3.8	-5.69
2024	2.23	-2.00 ⁸	4.6	-4.37

Beyond the challenges in physician payment created under MACRA, the Medicare Physician Fee Schedule (MPFS) is plagued by other challenges, including requirements to maintain budget neutrality, and slow, irregular updates to practice expense data used to set payments. In fact, physicians continue to “pay down” the significant budget neutrality adjustment prompted by CMS’ 2021 and 2023 implementation of increased relative values for office and outpatient evaluation and management (E/M) services and inpatient and other E/M services, respectively, as well as absorb CMS’ 2022 implementation of revised clinical labor prices (an update that lagged 2 decades). For 2024, CMS commenced paying for a new E/M add-on payment that Congress previously prohibited CMS from implementing, prompting yet another substantial budget neutrality adjustment and concomitant reduction to the PFS conversion factor. We appreciate congressional efforts to temporarily reduce conversion factor cuts, however, Congress has still allowed year after year of cuts to the MPFS conversion factor, and this pattern is unsustainable. In addition to congressionally-mandated stabilization of the MPFS conversion factor, it would be prudent to provide additional direction and authority to the Secretary to address these issues; for example, requiring the Agency to make consistent, ongoing updates to practice expense inputs and authorizing the Secretary to, in certain circumstances, waive or modify budget neutrality requirements.

As we have shared previously, the increasing downward financial pressure on physicians is forcing many to sell or merge their practices with hospitals, health systems, and private equity groups, which is reflected in an April 2022 report⁹ prepared by Avalere. According to the report, nearly 70% of all physicians are now employed—a figure that spiked 19% in 2021 alone. This follows a 2020 AMA survey¹⁰ which found that less than half of physicians are working in physician-owned practices. A consequence of increasing market consolidation is rising health care costs for payers, patients, and the federal and state governments. Indeed, as part of its March 2020 Report to the Congress,¹¹ MedPAC explained that:

[G]overnment policies have played a role in encouraging hospital acquisition of physician practices. For example, when hospitals acquire physician practices, Medicare payments increase due to facility fees that Medicare pays for physician services when they are integrated into a hospital’s outpatient department. The potential for facility fees from Medicare and higher commercial prices encourages hospitals to acquire physician practices and have physicians become hospital employees. (p. 458)

⁴Represents the budget-neutral MIPS adjustment for those earning a MIPS final score at the performance threshold; excludes additional payment bonuses under the Exceptional Performance Bonus.

⁵See the AMA History of Medicare Conversion Factors, <https://www.ama-assn.org/system/files/cf-history.pdf>.

⁶See Actual Regulation Market Basket Updates, <https://www.cms.gov/files/zip/actual-regulation-market-basket-updates.zip>.

⁷Difference in the payment rate between a conversion factor based on the budget-neutral MIPS payment adjustment and the payment rate adjusted for increases in practice costs as measured by inflation (e.g., MEI-adjusted conversion factor).

⁸Estimated annualized reduction in payments relative to CY 2023 factoring in fact that Congressional intervention did not apply until claims with dates of service on or after March 9, 2024.

⁹https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d.

¹⁰<https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice>.

¹¹https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf.

Physician-hospital integration, specifically hospital acquisition of physician practices, has caused an increase in Medicare spending and beneficiary cost sharing due to the introduction of hospital facility fees for physician office services that are provided in hospital outpatient departments. Taxpayer and beneficiary costs can double when certain services are provided in a physician office that is deemed part of a hospital outpatient department. (p. 460)

To what extent the MPFS contributes to rising health care costs because it encourages consolidation is something that warrants thorough examination and correction by Congress.

Ineffective Value Programs

Implementation of MACRA's two-track value-based payment system, the QPP, has been ineffective and, arguably, detrimental to the delivery of most specialty medical care. Many specialists perceive the QPP as an enormous administrative hassle that simply diverts critical resources away from more meaningful activities that could directly impact the quality and value of specialty care. Under MIPS, in particular, many specialty physicians often have no other choice but to report on marginally relevant measures that result in data that is of little use to physicians or their patients. Further, CMS has not produced any evidence to suggest that quality, efficiency, and outcomes for Medicare's seniors, the disabled, and underserved populations has demonstrably improved as a result of the MACRA-established quality programs.

As discussed below, most specialty physicians have also struggled to meaningfully engage in the APM track of the QPP, as there are only a few APMs that are applicable to specialty care. Through discussions with Alliance member organizations and the physicians they represent, we have found that Accountable Care Organizations (ACOs) are often the only option for APM engagement, and usually the result of specialists' hospital or health system employment, where any APM incentives are directed. Specialists often have little control over their decision to participate in these ACOs and the current set of metrics used to measure quality of care provided under the ACO do not reflect the more focused care provided by specialists.

Merit-based Incentive Payment System (MIPS)

In contrast to the promises of MACRA, MIPS has evolved into an overly complex, disjointed, burdensome, and clinically irrelevant program for many specialists. Even the U.S. Government Accountability Office (GAO),¹² in an October 2021 report, expressed concern that MIPS performance feedback is neither timely nor meaningful, questioned whether the program helps improve quality and patient outcomes, and highlighted the program's low return on investment. In its March 2024, environmental scan of value-based payment models,¹³ discussed earlier, PTAC notes: "Overall, there is little evidence that pay-for-performance and public reporting of quality measures have improved overall quality of care in the United States." The Alliance requests that Congress consider the following fundamental flaws that continue to plague MIPS:

- **Siloed Performance Categories.** CMS has failed to produce a more unified quality reporting structure, as promised under MACRA. MIPS continues to rely on four separate performance categories that each have distinct reporting requirements and scoring rules. Additionally, for many specialties, what is being measured on the quality side rarely aligns with what is being measured on the cost side, resulting in a flawed value equation. The Alliance has repeatedly asked CMS to provide cross-category credit for more robust value-based activities, such as reporting to a clinical data registry, which would minimize duplicative reporting and reward more innovative activities. However, CMS continues to cite statutory constraints, including the mandate to measure clinicians on each of the four MIPS performance categories as dictated by MACRA. As a result, the program is not only challenging to navigate and comply with, but for many specialties, it does not accurately reflect the overall value of care.
- **Constantly Shifting Goalposts.** Each year, CMS changes not only the MIPS eligibility rules and reporting requirements, but also the performance thresholds. As a result, it is challenging for physicians to keep up with the program and to make year-to-year comparisons regarding their performance. It is equally

¹² <https://www.gao.gov/assets/gao-22-104667.pdf>.

¹³ <https://aspe.hhs.gov/sites/default/files/documents/dae3de25b874112a649445d6381f527e/PTAC-Mar-25-Escan.pdf>.

challenging for CMS to accurately analyze the overall impact of the program over time.

- **Lack of Incentives for Specialty Measures.** Many specialties have also faced challenges developing more specialty-focused quality measures and getting members to report on those measures as a result of MIPS scoring policies and other challenging requirements associated with maintaining a QCDR;
 - QCDRs were authorized by Congress to provide a more flexible and rapid pathway for specialties to introduce more innovative and clinically relevant measures under MIPS. Instead, due to unnecessarily excessive and costly measure testing and data validation requirements imposed by CMS, many prominent specialty-sponsored registries have been given no other choice but to leave the program. This is unfortunate since clinician-led registries tend to collect more relevant and meaningful clinical outcomes data, including patient-reported outcomes data, that cannot be captured through claims. They also provide more timely and actionable feedback that is often more relevant to participating clinicians and their patient populations than what is provided by CMS under MIPS.
- **Flawed Cost Measures.** Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action on. They often reflect care decisions and costs that are outside of a specialist's direct control and rarely align directly with quality measures other than in title. For example, autoimmune diseases such as rheumatoid arthritis and Crohn's disease are managed with highly complex medications, including biologics and biosimilars. Depending on the patient's unique biology, disease progression, and other clinical factors, one therapy may be clinically-indicated, recommended and prescribed over another. Regardless of the condition or disease, measuring the cost of care *in isolation* is dangerous as it fails to account for the impact that changes in spending have on care quality and access to care.
- **Lack of Flexibility to Promote Interoperability.** The MIPS Promoting Interoperability category continues to take a one-size-fits-all approach to care that fails to appreciate the diversity and readiness of practices across the nation. The category also continues to focus on very specific electronic health record (EHR) functionalities rather than promote innovative use cases of health information technology, such as clinical data registries, clinical decision supports tools, and tracking data from wearables and other digital devices that are more common among specialty patients.
- **Lack of Alignment Across CMS Programs.** MIPS physician-level reporting requirements and measures largely fail to align with other CMS value-based incentive programs, including payment and delivery models, that apply to other providers and settings of care. For example, specialty practices submitting quality measure data for the Bundled Payments for Care Initiative—Advanced (BPCI-A) cannot simultaneously receive credit for the same measures under MIPS and must submit data for the two programs separately. This results in administrative redundancy, duplicative accountability, and conflicting incentives—particularly as it relates to team-based care coordination. This misalignment is costly for taxpayers and continues to make it challenging for Medicare to move the needle on the overall value of care for its beneficiaries.
- **Failure to Provide a Glidepath to APM Participation.** The intent of MIPS, as envisioned by MACRA, was to prepare physicians to move into APMs. However, the current program—even as recently revised through the MIPS Value Pathways (MVP) Framework—largely fails to align with measures used under APMs and does little to ready specialists to move into APMs. Further, there are ongoing barriers to APM participation among specialists, as explained below.
- **Misguided Efforts to Improve MIPS.** Although CMS' recently introduced MVP framework was intended to address many of the problems outlined above, it simply reshuffles the deck while doing very little to address the program's foundational flaws, which increases frustration and disillusionment among physicians at a time when worker burnout is at an historical high.

Advanced Alternative Payment Models (Advanced APMs)

Unfortunately, the APM track of the QPP is no less challenging. Alliance organizations continue to hear from their specialty physician members that active engagement in APMs is near impossible. Specialty-focused APMs exist, but they only consider a limited number of conditions or procedures, leaving the vast majority of specialists without a dedicated model. Others, such as the BPCI-A program, do not align with other physician quality reporting requirements under MIPS and fail to provide high performing practices with an incentive to stay in the program since they are held to exceedingly high cost targets that simply do not support high qual-

ity, appropriate care. Additionally, as discussed earlier, specialists that are “participants” in ACOs are usually part of large hospitals or health systems, but their role is passive; they do not meaningfully engage in quality improvement or cost containment activities specific to the ACO, as the accountability measures do not consider the conditions they treat, nor services provide. Other specialists that attempt to join ACOs are blocked from entry by the primary care physicians who lead them.

These findings are not just speculative. As highlighted in MedPAC’s July 2022 Data Book,¹⁴ *Health Care Spending and the Medicare Program*,

Many specialties account for a larger share of clinicians in larger ACOs. This finding may reflect smaller ACOs being more often composed of independent physician practices with relatively fewer specialists, while larger ACOs are often affiliated with hospitals or health systems that have a broader range of specialists. (p. 44)

MedPAC also explains that,

Specialists’ participation in ACOs relative to their share of all clinicians varies by specialty. For example, cardiologists comprise about 2 percent of all clinicians participating in FFS Medicare, but a larger share of clinicians participating in ACOs. By contrast, specialties such as anesthesiology and ophthalmology are underrepresented in ACOs relative to their share of all FFS clinicians. (p. 44)

At the outset of the QPP, the Alliance and its member organizations—independently and collectively—proactively connected with the ACO member organization to discuss opportunities for improving specialists’ participation in ACOs. One approach discussed, which is contemplated in a recent Health Affairs blog post by senior CMS Innovation Center officials,¹⁵ was the development of “shadow bundles.” This concept of nesting more specific episode-based or condition-specific models in population-based total cost of care (PB-TCOC) models was also discussed in PTAC’s 2023 Request for Information (RFI) on Integrating Specialty Care in Population-Based Models¹⁶ and its follow-up 2024 RFI on Implementing Performance Measures for PB-TCOC.¹⁷ At the time, further attempts to coalesce around this concept with the ACO community were stalled. Ultimately, we were told that specialty medical care and treatment was expensive and hurt ACOs financial performance, and—in the case of primary care-led ACOs—there was no appetite for sharing “savings” with specialists.

The Alliance appreciates the CMS Innovation Center’s recent recognition that a comprehensive approach to accountable care must account for both primary care and specialty care, and that it is exploring opportunities to build on the shadow bundle concept. Some Alliance member organizations have already invested in this type of work, yet they continue to face challenges in terms of getting CMS to adopt these models. The American Society of Cataract and Refractive Surgery (ASCRS), for example, developed the Bundled Payment for Same-Day Bilateral Cataract Surgery (BPBCS), which aims to promote same-day bilateral cataract surgery to appropriate patients at a lower cost for both patients and Medicare. Under this model, the Cataract Surgery Team (the surgeon, facility, and anesthesiologist) would receive a single bundled payment—rather than separate payments—for all services associated with the surgery. Importantly, the patient would also have a single cost-sharing amount for those services and there would be fewer trips needed to the surgery center and to the physician for follow-up visits, which would reduce out-of-pocket expenses for the patient and family. This model supports a team-based approach to care that promotes efficiencies that will result in the best outcomes at the lowest possible cost. Despite multiple encouraging meetings where CMS leadership expressed support for the model, the agency has yet to take any action. As a result, ASCRS has begun to explore alternative pathways, including working with Medicare Advantage plans to test the model. The BPBCS is an example of a thoughtfully developed framework that could work in tandem with CMS population-based, total-cost-of-care models—such as ACOs—as a separate voluntary agreement with a cata-

¹⁴ https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_SEC-v2.pdf.

¹⁵ <https://www.healthaffairs.org/content/forefront/cms-innovation-center-s-strategy-support-person-centered-value-based-specialty-care>.

¹⁶ <https://aspe.hhs.gov/sites/default/files/documents/2cd91b29eac2742fbc9babaf8f3b7962/PTAC-Specialty-Integration-RFI.pdf>.

¹⁷ <https://aspe.hhs.gov/sites/default/files/documents/823f7133bbde9de118d693a4330d2645/PTAC-Perf-Meas-RFI.pdf>.

ract surgery team, without requiring specialists to be part of an ACO. The Alliance continues to urge CMS and the Innovation Center to work more closely with the specialty community and to take advantage of investments that have already been made in this space.

The specialty community has also faced challenges in terms of accessing data that will help it to better understand specialty engagement in, and barriers to, APM participation. Despite multiple requests, both CMS and MedPAC have flat-out refused to provide data on the number and type of specialists in APMs to help us better understand and overcome these challenges. As noted earlier, just last month, PTAC finally released some basic data on the participation rates of select specialties in Advanced APMs; however, the data are over 5 years old and provide no insight on more current trends.

Making matters worse is the fact that under MACRA, the 5% Medicare incentive payment that has been offered since 2019 (based on 2017 APM participation) to clinicians who are Qualifying Participants (QP) in an Advanced APM was set to expire after the 2022 performance/2024 payment year. Congress subsequently extended this incentive payment an additional year, but at a reduced rate of 3.5%, and then again, for the 2024 performance/2026 payment year, but at a further reduced rate of 1.75%. Moving forward, as mandated under MACRA, physicians who qualify as QPs will only receive a nominal base conversion factor update starting in 2025 (0.75 percent vs. 0.25 percent for non-QPs, including MIPS participants who are also eligible for upward performance-based payment adjustments), limiting their incentives to join APMs going forward.

MACRA also prescribes specific Medicare payment and patient thresholds that clinicians must meet to become QPs. Beginning with the 2023 performance year, the Medicare QP Thresholds were supposed to increase to 75% (from 50%) for the payment amount method and 50% (from 35%) for the patient count method, making it more challenging for physicians to meet the definition of a QP. While Congress froze these thresholds at the lower levels for 2023 and 2024, they are scheduled to increase in 2025 without Congressional action.

While the Alliance appreciates the steps Congress has taken to date in an attempt to continue to support movement of physicians into APMs, it is still very concerned about the negative impact these shifting policies will have on the already slow movement of specialists into APMs. There have been very limited opportunities for specialists to participate meaningfully in APMs and qualify as QPs to date. With the expiring APM incentive payment, most specialists will never even have had the opportunity to qualify for this critical source of funding, which has been immensely helpful to physicians who must invest in infrastructure and analytics to participate meaningfully in an APM. Similarly, higher QP thresholds will result in even fewer specialists qualifying for this track.

Finally, as mentioned earlier in the context of MIPS, CMS suffers from internal disorganization in its administration of Medicare value-based initiatives. Multiple offices within CMS are responsible for managing similar, but separate, value-focused initiatives authorized by MACRA, with little apparent coordination. For example, the staff responsible for administering the QPP seem disconnected from the CMMI staff administering APMs, despite the intrinsic link between the two, which results in duplicative reporting and accountability for clinicians. Additionally, to carry out these initiatives, CMS relies on numerous contractors who are not aligned or coordinated with one another, which leads to confusion, inefficiencies, and situations where individuals with no institutional historical knowledge and very little understanding of the clinical implications of their recommendations and actions are making important decisions.

Recommendations to Improve MACRA

Congress sought to provide flexible options for clinicians to engage in meaningful quality improvement and value-based care in the Medicare program. However, the implementation of these statutory quality programs has resulted in a rigid system that holds physicians accountable for metrics and models that often do not apply to them. We contend that MACRA must be overhauled and replaced with a payment system that:

- Ensures financial stability and predictability in the Medicare Physician Fee Schedule;
- Promotes and rewards value-based care innovation that meaningfully improves patient care and outcomes, particularly within specialty care; and

- Safeguards timely access to high-quality care by advancing health equity and reducing disparities.

This can be accomplished by acting on the aforementioned recommendations. In addition, members of the Alliance participated in efforts by the AMA to develop its “Characteristics of a Rational Medicare Payment System”¹⁸ and urge you to incorporate these principles in any physician payment reform solution.

We look forward to working with the committee to ensure specialty physician practice viability and success and will be happy to discuss any other questions you may have going forward.

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Chairman Wyden and Ranking Member Crapo, on behalf of the more than 17,000 U.S. members of the American Academy of Dermatology Association (AADA), we thank you for the opportunity to submit a statement for the record regarding your hearing, “Bolstering Chronic Care through Medicare Physician Payment.”

As you explore ways to modernize and strengthen Medicare for seniors, one critical aspect that needs immediate attention is the instability of the Medicare physician payment system and the need for reform. The AADA firmly believes that Congress must take action to advance Medicare physician payment reform by:

- Establishing a positive annual inflation adjustment.
- Increasing the budget neutrality threshold, supporting a lookback period to rectify errors associated with utilization assumptions, and allowing specific services to be excluded from budget neutrality requirements.
- Reforming the Quality Payment Program (QPP) to increase physician input and improve patient care without overly burdensome documentation and compliance activity.

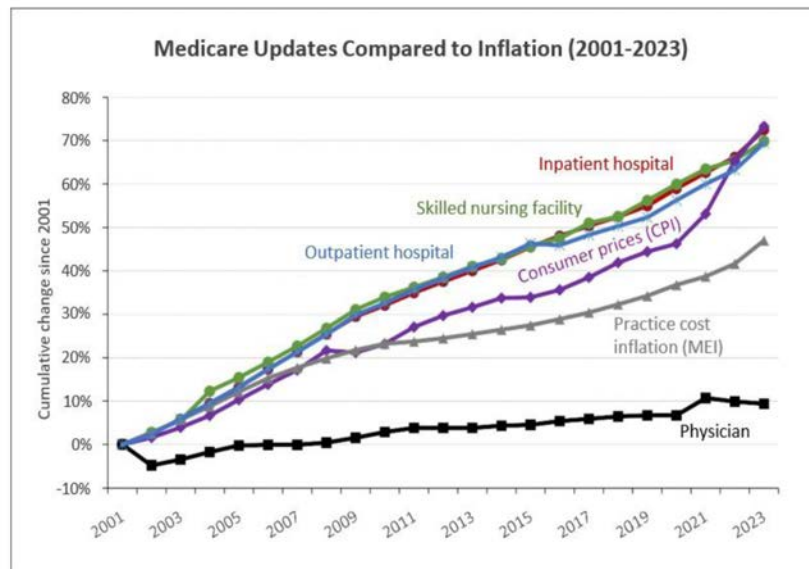
In addition to these reforms, it’s important to emphasize that Americans should have access to affordable, high-quality dermatologic care with the freedom to choose their own physicians and health insurance that best meets their needs. The Medicare program must ensure beneficiaries have adequate access to networks of specialists and subspecialists, including board-certified dermatologists. This goal can only be possible when health care policy is driven by the welfare of patients over short-sighted and siloed budgetary policies that increase overall health care spending and further erode the stability and predictability of the Medicare system.

Inflation and the Siloed Medicare Program Structure

The failure of the Medicare Physician Fee Schedule (MPFS) to keep up with inflation is the greatest threat to maintaining seniors’ timely access to care in physician offices. Hospitals and other healthcare facilities receive Medicare payment updates, but physicians receiving payments under the MPFS are excluded from this type of adjustment. In fact, CMS finalized a 3.4% cut in the Calendar Year (CY) 2024 MPFS final rule. While the AADA appreciates the partial relief Congress provided to the MPFS in the Consolidated Appropriations Act, 2024, physician payments still ultimately received a cut from 2023.

Since 2001, the cost of operating a medical practice has increased 47%. During this time, Medicare hospital and nursing facility updates resulted in a roughly 70% increase in payments to these entities, significantly outpacing physician reimbursement. *Adjusted for inflation in practice costs, Medicare physician reimbursement declined 30% from 2001 to 2024.* This out-of-balance payment structure disproportionately threatens the viability of medical practices, especially smaller, independent, physician-owned practices, as well as those serving low-income or historically marginalized patients. This issue is further exacerbated by rising costs and inflation, leading to increased consolidation and hospital ownership of physician practices, resulting in higher expenses and reduced competition.

¹⁸<https://www.ama-assn.org/system/files/characteristics-rational-medicare-payment-principles-signatories.pdf>.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

Congress and CMS need to re-examine the siloed approach to reimbursement tied to the Medicare program. According to the 2020 and 2021 Medicare Trustees' report, MPFS spending per enrollee was \$2,107 in 2011 and \$2,389 in 2021, growing at an average annual rate of 1.3%. However, in contrast, Medicare spending per enrollee in Part A fee-for-service (FFS) was \$5,178 in 2011 and \$5,576 in 2021—a 7.7% increase and more than double the cost per patient treated under the MPFS.

In considering the failure of the MPFS to keep up with the rising costs of delivering medical care, it is important to remember that physicians rely on reimbursement to cover a multitude of practice expenses. These expenses include staff salaries, benefits, federal and state regulatory compliance costs, and expenses associated with insurance mandates, such as step therapy and prior authorization. Moreover, technology requirements associated with compliance of the QPP are costly and contribute to the financial strain placed on physician offices.

Physician practices are often small businesses that contribute to the economy of their communities. Other industries can adjust their products' pricing to reflect rising costs and increased staff salaries. However, physicians do not have the ability to do this. In fact, in the face of crippling inflation the MPFS serves to destabilize practices with year-after-year cuts. Such a structure is unsustainable, and we must not expect physicians delivering essential medical care to Medicare beneficiaries and their communities to endure it. Many physicians have already had to close their doors, leave their communities, retire early, or leave the practice of medicine. The below chart demonstrates the staggering numbers of physicians leaving the workforce, and this trend will continue as nearly 45% of physicians are older than age 55. The loss of experienced physicians is detrimental to patient outcomes and the young physicians who rely on them as a learning resource.¹

¹ <https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the-healthcare-staffing-shortage-2023.pdf>.

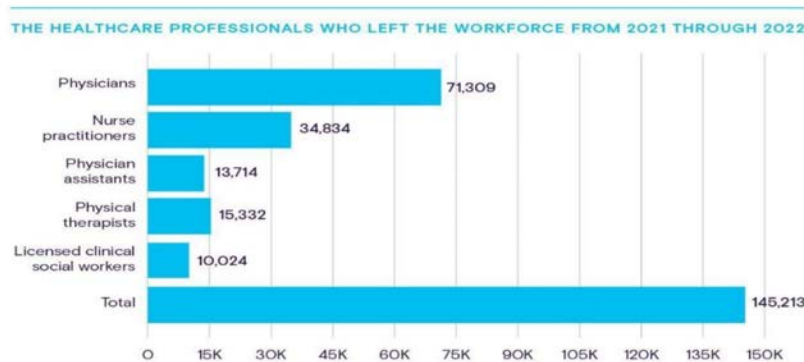


Fig. 1 Analysis of data from Definitive Healthcare's Atlas All-Payer Claims and PhysicianView products. Data sourced from a stable panel of billing organizations from Q1 2021 through Q1 2023. Physicians deemed as dropped out practiced in 2021 and ceased activity by Q4 of 2022. Some providers may still be practicing, but not filing claims. Data accessed September 2023.

The inability to provide inflationary pay raises to practice employees is contributing to the current healthcare workforce crisis in which we are seeing increasing burnout rates and a mass exodus of our clinical, administrative, and clerical staff into other industries. With reduced staff comes a diminished capacity to provide quality care and maintain patient access. Reduced staffing leads to barriers in communicating and coordinating care, such as scheduling appointments and discussing lab reports, which can impact patient satisfaction and outcomes.

The threat of future additional cuts to Medicare physician reimbursement jeopardizes physicians' ability to keep the doors open and care for patients in our communities. Fewer physicians in our communities means longer wait times for patients to receive care. When those patients do receive care, their only option may be non-physician providers of care with less training, or more expensive care in suboptimal settings including emergency departments and hospital-based practices. This is real, not theoretical, and is already occurring in our communities. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost.

Physicians need positive, inflation-based reimbursement updates to maintain financial stability and ensure patients have continued access to care. Inflationary updates tied to the Medicare Economic Index (MEI) need to be based on current data. In fact, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress tie physician payment updates to the Medicare Economic Index (MEI) or practice cost inflation rates for 2025.² Specifically, MedPAC recommended that Congress update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50% of the projected increase in the MEI. Based on CMS's MEI projections at the time of the publication of the March 2024 MedPAC Report to Congress, the recommended update for 2025 would be equivalent to 1.3% above current law.

The AADA appreciates MedPAC's acknowledgment that the current Medicare physician payment system has not kept up with the cost of practicing medicine. While we value this recognition, Congress should adopt a 2025 Medicare payment update that fully acknowledges the inflationary growth of health care costs. This step is crucial for ensuring financial stability in the Medicare physician payment system and maintaining continued access to high-quality patient care.

The AADA urges Congress to pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which would provide an inflationary update to the conversion factor under the Medicare Physician Fee Schedule based on the Medicare economic index.

² <https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/>.

Budget Neutrality

Downward pressure on Medicare reimbursement is due to budget neutrality requirements. This has resulted in a decline of 26% since 2001. The Medicare statute requires that changes made to fee schedule payments be implemented in a budget-neutral manner.

Furthermore, by law, CMS must also create utilization assumptions for newly introduced services. When an overestimation occurs, it remains uncorrectable, leading to irreversible reductions in the funding allocated to the Medicare physician payment pool. For example, in 2013, transitional care management services were added to the MPFS. While CMS estimated 5.6 million new claims, actual utilization was under 300,000 for the first year and less than a million claims after 3 years. This overestimation led to a \$5.2 billion reduction in Medicare physician payments from 2013 to 2021. This example highlights the unintended consequences of the current budget policies within the flawed system. We firmly believe that CMS should have the authority to rectify utilization assumption errors that impact budget neutrality.

In the absence of eliminating budget neutrality policy, we encourage Congress to pass H.R. 6371, the Provider Reimbursement Stability Act, to revise the budget neutrality policies to: (a) prevent erroneous utilization estimates from leading to inappropriate cuts; (b) clarify the types of services subject to budget neutrality adjustments; and (c) update the projected expenditure threshold triggering the budget neutrality adjustment, which has remained unchanged since 1992.

Reform Quality Payment Program

Value-Based Models

Current value-based programs are burdensome, have not demonstrated improved care, and are not clinically relevant to the physician or the patient, and we have serious concerns with the viability and effectiveness of the Merit-based Incentive Payment System (MIPS) program. Numerous studies have highlighted persistent challenges associated with MIPS, including practices serving high-risk patients and those that are small or in rural areas. A study titled “Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk,” examined whether MIPS disproportionately penalized surgeons who care for patients at high social risk. This study found a connection between caring for high social risk patients, lower MIPS scores, and a higher likelihood of facing negative payment adjustments.³

Additionally, the Government Accountability Office (GAO) was tasked with reviewing several aspects concerning small and rural practices in relation to Medicare payment incentive programs, including MIPS. The GAO’s findings indicated that physician practices with 15 or fewer providers, whether located in rural or non-rural areas, had a higher likelihood of receiving negative payment adjustments in Medicare incentive programs compared to larger practices.⁴

These studies highlight flaws in traditional MIPS, particularly in terms of potential disparities in care and the financial burdens placed on physicians when caring for high-risk patient populations and physicians in small practices. **The AADA recommends that Congress establish incentives, funding, and flexibility for physician offices with targeting small and solo practices.**

MIPS Value Pathways

Since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS routinely introduces new changes to MIPS, requiring physicians to adjust continuously. Physicians are increasingly frustrated by the frequent modifications to the Quality Payment Program (QPP), including the associated administrative burdens of adhering to new program requirements and the lack of incentive payments to adequately compensate for participation efforts. While the AADA acknowledges CMS’ attempt to address some of these concerns by introducing MIPS Value Pathways (MVPs) aimed at creating more meaningful groups of measures and

³Byrd JN, Chung KC. Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk. *JAMA Surg.* 2021;156(11):1018–1024. doi:10.1001/jamasurg.2021.3746.

⁴Medicare Small and Rural Practices’ Experiences in Previous Programs and Expected Performance in the Merit-Based Incentive Payment System. Report to Congressional Requesters. United States Government Accountability Office. 2018. <https://www.gao.gov/assets/gao-18-428.pdf>.

activities to offer a more comprehensive assessment of quality of care, this new reporting option is falling short of achieving the Agency's goal.

The AADA has significant concerns with the Agency's approach to constructing MVPs, as it is using excessively broad measure sets that lack alignment and provide no added benefit in terms of enhancing patient care or helping patients determine the value of the clinician managing their care. CMS' approach fails to account for the realities of clinical practice and adds yet another layer of complexity to an already confusing program. Take for example, CMS' candidate MVP for Dermatological Care. Despite nearly 2 years of discussions and meetings between CMS and the AADA, CMS continues to express interest in the use of a single MVP for dermatology. This decision ignores the critical problem of a one-size-fits-all approach, as it cannot effectively compare costs and quality of care. We have shared with CMS that each subspecialty within dermatology provides unique services to distinct patient populations with varying practice patterns. This diversity in the practice of dermatology makes a one-size-fits-all model ineffective for comparing the cost and quality of care. For instance, dermatologists who treat psoriasis, which is currently considered in the candidate MVP's quality measures may not treat melanoma, which is currently the only measure related to cost available in the candidate MVP. Regardless of how CMS ultimately scores MVP participants, if CMS finalizes an MVP that includes a cost measure for a cancer-related disease and quality measures for an inflammatory skin disease, patients and clinicians will question its purpose and the extent to which it fails to drive value-based care.

Due to these numerous concerns, the AADA calls on Congress to urge CMS to pause on moving forward with the MVPs. The AADA welcomes the opportunity to continue working with CMS and the Congress to identify opportunities to improve quality, patient outcomes, and efficiencies.

Burden on Physician Practices

Furthermore, the QPP must keep a keen focus on preventing physician and staff burnout based on the Department of Health and Human Services (HHS)⁵ own priorities. This includes providing relief from systems-level factors that contribute to healthcare worker burnout by instituting measures that:

- Implement systems changes that reduce administrative paperwork overall.
- Facilitate coordination at the systems level without adding administrative burden to healthcare practices and healthcare workers.
- Provide funds to purchase human-centered technology that facilitates providing value-based care; and
- Ensure engagement in value-based care does not lead to additional workload, overhead, and work hours for specialists.

Conclusion

On behalf of the AADA and its member dermatologists, thank you for holding this hearing, allowing the opportunity for stakeholders to submit a statement for the record, and for your commitment to ensuring physicians can continue to serve their Medicare patients. The AADA looks forward to working with you and asks that you continue to consider including physician stakeholders' opinions in your ongoing hearings as you work to identify a permanent solution to stabilize the Medicare physician payment program. Should you have any questions, please contact Adam Harbison, Director of Congressional Affairs at aharbison@aad.org.

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Members of the United States Senate Committee on Finance, thank you for holding this important hearing. We submit this statement for the record on behalf of the American Academy of Home Care Medicine (www.aahcm.org) to alert the committee about the status of the Independence at Home (IAH) demonstration and to provide suggestions for extension and revitalization of the model, especially to ensure access to home-based primary care for those living with multiple complex chronic conditions.

⁵ <https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf>.

History of Independence at Home and the Growing Need for Home-Based Primary Care

For Medicare, home-based primary care brings multiple rewards—enhancing quality of service and access to care for our nation’s most ill elders and their families while achieving the important side effect of cost savings for Medicare. The Independence at Home (IAH) demonstration under the Centers for Medicare and Medicaid Services Innovation Center (CMMI) began in 2012 as first authorized by Section 3024 of the Affordable Care Act. Since its inception the demonstration received strong bipartisan support and was extended three times by Congress in the last decade, though never expanded to bring in additional practices.

Under the demonstration, health care providers are rewarded for providing high quality home-based primary care (HBPC) while reducing costs. Focused on care for Medicare patients who have multiple chronic conditions and disability, the IAH model uses mobile interdisciplinary teams of medical and social service professionals to care for patients in their homes, delivering high quality clinical care, excellent patient experience, and significantly lower costs for the Medicare program.

The demonstration was rooted in the reality that high-need Medicare beneficiaries account for a disproportionate share of health care spending. The IAH demonstration used simple criteria, apparent to a clinician seeing a patient, yet also attributable through claims, to identify this group:

- Have two or more chronic conditions, expected to persist for more than a year.
- Have coverage from fee-for-serve Medicare A and B.
- Needs personal assistance with 2 or more activities of daily living such as bathing, dressing.
- Had a non-elective hospital admission in the last 12 months.
- Received Medicare Part A post-acute skilled services in the last 12 months.

At the start of the demonstration, such individuals represented 6% of the Traditional Medicare population but accounted for 30% of Traditional Medicare spending. Today, those qualified for IAH represent nearly 11% of the Traditional Medicare population and account for 44% of Traditional Medicare spending. The number of Traditional Medicare beneficiaries who would qualify for Independence at Home has increased by over 1.2 million since the start of the demonstration, but the number receiving home based primary care has increased by less than 300,000. There are nearly 2 million more seniors who could be benefitting from home-based primary care as delivered by the IAH model but are not currently receiving these services. This number will only grow as the population continues to age, with the first Baby Boomers turning 80 in 2026.

The growing number of seniors in need of home-based primary care, the insufficient supply of home-based primary care providers, particularly in rural and underserved areas, and the increasing share of Medicare costs associated with high need patients all require an effective program that can meet the needs of such patients.

Independence at Home Model Works for Patients, Families, Communities, and Providers

Patients, Families, and Communities

Many older adults living with severe chronic illnesses and disability have trouble traveling to the doctor’s office, forcing them to rely on the emergency department or hospital due to cognitive, physical, or social barriers. Homebound seniors are more likely to be socially and economically disadvantaged, and are often socially isolated, with unmet care needs. For seriously ill elders, providing 24/7 medical and social services at home allows them to live a life with dignity and respect, where they want to be . . . at home. It brings peace of mind to family caregivers by coordinating all needed health services, prepares patients and families for managing serious illness, and supports them until the last day of life.

IAH practices can deliver many services available in an urgent care center or hospital room—portable diagnostic, therapeutic, and monitoring technologies that allow the patient to stay at home, rather than come to the hospital. These services include urgent medical visits, blood tests, X-rays, EKGs, IV medications, oxygen, social work, and caregiver education. By providing such services, elders and families gain access to skilled primary care, maximize their time at home, call 911 less often, and are admitted less often to the hospital. For providers and health systems, the practice of house calls is an old idea, improved with modern technology. By visiting the home, providers build close relationships and trust with patients and families, leading to more accurate diagnosis and more effective treatment.

Through receipt of high-quality care at home, IAH patients experience better quality outcomes. IAH providers are measured on six quality metrics, including all-cause hospital readmissions, ambulatory sensitive hospital admissions, and emergency department visits. In Year 8 of the demonstration, the median participant reduced readmissions by 23%, hospital admissions by 41%, and ED visits by 31%. These remarkable reductions in healthcare utilization translate into what matters most to patients: more time at home, less time cycling in and out of healthcare facilities.

Providers

IAH was designed to bring home based primary care practices into value-based care, with adequate resources to field the mobile teams these patients require. IAH providers serve as the “quarterback” of a mobile team, coordinating medical care and social services that are often as important as medical treatment. These mobile teams of Physicians, Nurse Practitioners or Physician Assistants, and Social Workers address routine and urgent issues and manage nearly all needed care in the home. IAH also encourages innovation in telehealth services. For example, some IAH sites have implemented tele-video after-hours or used specially trained paramedics to keep patients at home and out of the hospital. Many of these services are not reimbursed by traditional Medicare or are reimbursed at rates well below the cost to provide them.

The IAH model allows health care providers to achieve the following goals.

- Spend more time with their patients.
- Perform assessments in a patient’s home environment.
- Assume greater accountability for all aspects of a patient’s care.
- Prevent chronic conditions from getting worse.
- Avoid unnecessary emergency department visits and hospitalizations.
- Improve patient and caregiver satisfaction.
- Lower overall costs to Medicare.

The field of home-based primary care overwhelmingly consists of small practices: only 8% of practices have more than 750 patients. Of the over 2,400 home-based primary care practices in 2021, 2,200 of them had fewer than 500 patients. These practices are small businesses that serve a critical role, providing high quality healthcare jobs in their local communities. Delivering equivalent quality of care than larger practices, small practices are also more likely (19% higher) to be in underserved areas—the Area Deprivation Index, a composite metric of how socially disadvantaged a geographic area is.

How the IAH Demonstration Functioned

According to CMS’s independent model evaluation, over the 8 years for which results are available, IAH practices have delivered care at \$229 million less than expected, or an average of \$3,100 per beneficiary per year less than expected.¹ These cost reductions have generated \$148 million in net savings for CMS. Participants have generated savings in every single year of the model. IAH practices have also reduced hospitalizations 20% and increased the time that patients spend at home by 13%. Patients of IAH practices have a 40% lower risk of entering a nursing home long term.

Participants also showed signs of improvement throughout the duration of the model. In the first year, 12 of the 17 practices delivered care at costs less than expected, while by Year 5 all practices were delivering care at lower-than-expected costs. Practices that were not initially delivering lower costs improved to a point where they were saving \$330 per beneficiary per month. Practices that were already delivering low-cost care at the start of the model increased the savings they delivered from \$400 per beneficiary per month initially to over \$700 per beneficiary per month in Year 8.

The IAH demonstration successfully enrolled high need patients, who cost on average \$40–\$50,000 per year, throughout its 10 years of operation. IAH was initially capped at only 10,000 beneficiaries and never allowed new practices to join after the start of the model. Despite these limitations, the demonstration retained over 80% of its original participating practices through Year 5. Through Year 5, IAH partici-

¹ CMS uses a difference-in-difference methodology to calculate savings generated by the model. Under this methodology, the total savings over 8 years has been \$117 million, or \$201 per beneficiary per month. However, this approach does not account for the lower costs that IAH participants were already generating before they started the model. Adjusting CMS’s methodology to account for these lower costs pre-model produces the \$229 million savings estimate.

pants saved an average of \$2,800 per beneficiary per year, for an average savings rate of 6%.

After Year 5, some practices moved from IAH to other value-based models that offered better cash flow to maintain operations. In the original IAH design, practices would wait 18–24 months to receive any shared savings. Despite newer CMMI models that could accommodate home-based primary care practices, such as CPC+ and Primary Care First, nearly 60% of the IAH practices remained in the demonstration through Year 7 because the primary care models didn't provide sufficient resources for high need patient care. Over the last 2 years of the demonstration, the remaining IAH practices have migrated to the High Needs Direct Contracting/High Needs ACO REACH model, while still delivering high value care. Unfortunately, the High Needs program excludes nearly a quarter of IAH qualified beneficiaries, has a minimum size requirement that excludes 96% of home-based primary care practices, and requires a level of down-side risk that few primary care practices can accept. High Needs ACO REACH is only an option for either the largest home-based primary care practices or practices that are willing to use a third-party aggregator, which typically takes a large portion of any savings earned.

Apply Lessons Learned to Improve, Expand Independence at Home Model

IAH could benefit nearly two million more Medicare beneficiaries with multiple chronic conditions and disability, the fastest growing and most costly segment of the Medicare population. IAH pays for itself from savings to the Medicare program through a smarter use of resources, providing monitoring and maintenance therapy and using technologically enhanced urgent care services in the home. IAH also eases the overwhelming demand from those living with severe chronic illness and disability, who wish to avoid institutionalization.

The Independence at Home model has benefited from over a decade of experience, including lessons learned from other value-based systems. See Exhibit 1 at end summarizing the many studies and analyses of the Independence at Home model.

With a revitalization of the model, IAH could address the **significant disparities** in who has access to home-based primary care in their community today. The current supply of home-based primary care is concentrated in urban metropolitan areas. According to one study, rural residents were 78% less likely to receive home-based care than residents of the largest metropolitan county.²

We humbly ask the committee to not waste the precious resources devoted to this program over the last decade and to capitalize on the promise for IAH's future, especially given the growing need for home-based primary care in the aging Medicare population. We ask that you work with us to extend and revitalize the model in a few modest ways to ensure that it can continue to serve our nation's elderly. Modifications include better targeting beneficiaries in need, providing appropriate financial incentives and supports, bolstering practices with additional care management tools, and incorporating a broader set of services.

Provide Caregiver Assessment and Support

- Expand the HBPC model to a new cohort of practices without a beneficiary cap.
- Include voluntary and claims-based alignment.
- Align all beneficiaries who receive a plurality of primary care from the participating practice; at least 30% of a practice's patients must meet High Needs criteria to be eligible for the model.

Provide Appropriate Financial Incentives and Supports

- Introduce monthly enhanced primary care and health equity payments to support care investments.
- Reduce Medicare's guaranteed discount to ACO REACH levels.
- Use a concurrent risk adjustment methodology.

Bolster Practices with Additional Care Management Tools

- Provide monthly performance data in a user-friendly format.
- Allow benefit enhancements such as the cost sharing waiver, SNF 3-day waiver, and nurse practitioner provision of service waivers.

Incorporate a Broader Set of Services

- Unpaid caregiver support.
- Coordination and management of home- and community-based services.

²Yao N, Richie C, Cornwall T and Leff B. Use of Home-Based Medical Care and Disparities. *Journal of the American Geriatrics Society*. 07 August 2018.

Thank you for your committee's focus on home care for our nation's seniors. Providers and allies of the American Academy of Home Care stand with you and commit to assisting you in the laudable goal of best serving our nation's seniors.

For further information, contact Peggy Tighe at Peggy.Tighe@PowersLaw.com or Emily Johnson at ejohnson@bloomhealthcare.com.

**Exhibit 1: The Independence at Home Demonstration,
A Table Review of the Literature**

Title	Authors	Publication/Link	Year
Laying the Groundwork for Independence at Home			
Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders	Eric De Jonge et al.	62 J. Am. Geriatrics Soc'y ¹	2014
Better Access, Quality, and Cost for Clinically Complex Veterans with Home-Based Primary Care	Thomas Edes et al.	62 J. Am. Geriatrics Soc'y ²	2014
Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial	Steven R. Counsell, Christopher M. Callahan, Daniel O. Clark et al.	298 JAMA ³	2007
Analysis of Independence at Home Results			
Independence at Home: After 10 Years of Evidence, It's Time for a Permanent Medicare Program	Konstantinos E. Deligiannidis, Peter Boling, George Taler, Bruce Leff, & Bruce Kinorian	71 J. Am. Geriatrics Soc'y ⁴	2023
Evaluation of the Independence at Home Demonstration: An Examination of Year 7, the First Year of the COVID-19 Pandemic	Laura Kimmey, Jason Rotter, Joseph Lovins, & Rachel Kogan	Mathematica ⁵	2023
Letter to the Editor: Independence at Home Evaluation Findings Do Not Support Creating a Permanent Medicare Program	Laura Kimmey & Jason Rotter	72 J. Am. Geriatrics Soc'y ⁶	2023
Reply to: Independence at Home Evaluation Findings Do Not Support Creating a Permanent Medicare Program—It Does	Konstantinos E. Deligiannidis et al.	72 J. Am. Geriatrics Soc'y ⁷	2023
The Underappreciated Success of Home-Based Primary Care: Next Steps for CMS' Independence at Home	Katherine Ornstein, David M. Levine, & Bruce Leff	69 J. Am. Geriatrics Soc'y ⁸	2021
Comment on: The Underappreciated Success of Home-Based Primary Care: Next Steps for CMS' Independence at Home	Laura Kimmey & Valerie Cheh	70 J. Am. Geriatrics Soc'y ⁹	2022
Reply to: Comment on: The Underappreciated Success of Home-Based Primary Care: Next Steps for CMS' Independence at Home	Katherine Ornstein, David M. Levine, & Bruce Leff	70 J. Am. Geriatrics Soc'y ¹⁰	2022

**Exhibit 1: The Independence at Home Demonstration,
A Table Review of the Literature—Continued**

Title	Authors	Publication/Link	Year
Analysis of Independence at Home Results			
Integrated Home- and Community-Based Services Improve Community Survival Among Independence at Home Medicare Beneficiaries Without Increasing Medicaid Costs	Girish Valluru et al.	67 J. Am. Geriatrics Soc'y ¹¹	2019
Randomized Controlled Trials			
Outcomes of Home-Based Primary Care for Homebound Older Adults: A Randomized Clinical Trial	Alex D. Federman et al.	71 J. Am. Geriatrics Soc'y ¹²	2022
Editorial: The Challenge of Proving the Value of Medical Care in the Home	Peter A. Boling & Bruce Kinoshian	71 J. Am. Geriatrics Soc'y ¹³	2022
Expanding Independence at Home: Model Projection Papers			
Home-Based Primary Care: Beyond Extension of the Independence at Home Demonstration	James Rotenberg et al.	66 J. Am. Geriatrics Soc'y ¹⁴	2018
Projected Savings and Workforce Transformation from Converting Independence at Home to a Medicare Benefit	Bruce Kinoshian, George Taler, & Peter Boling	64 J. Am. Geriatrics Soc'y ¹⁵	2016
Targeting Frail High Cost Veterans Improves Impact and Efficiency of Home Based Primary Care (HBPC)	T.E. Edes et al.	1 Innovation in Aging ¹⁶	2017
To Strengthen the Primary Care First Model for the Most Frail, Look to the Independence at Home Demonstration	Bruce Leff, Peter Boling, George Taler, & Bruce Kinoshian	Health Affairs Blog ¹⁷	2020
Home-Based Care Systematic Reviews of Outcomes			
Systematic Review of Outcomes from Home-Based Primary Care Programs for Homebound Older Adults	Nathan Stall, Mark Nowaczynski, & Samir K. Sinha	62 J. Am. Geriatrics Soc'y ¹⁸	2014
Comparative Effectiveness Review No. 164: Home Based Primary Care Interventions	Agency for Healthcare Rsch. and Quality, U.S. Dep't of HHS.	AHRQ ¹⁹	2016
Home-Based Primary Care: A Systematic Review of the Literature, 2010–2020	Robert M. Zimbroff, Katherine A. Ornstein, & Orla C. Sheehan	69 J. Am. Geriatrics Soc'y ²⁰	2021
Continuing Need for and Disparities in Access to Home-Based Care			
Primary Care in the Home: The Independence at Home Demonstration in Primary Care for Older Adults	George Taler, Peter Boling, & Bruce Kinoshian	Primary Care for Older Adults ²¹	2018
Use of Home-Based Clinical Care and Long-Term Services and Supports Among Homebound Older Adults	Jennifer M. Reckrey et al.	24 J. Am. Medical Directors Association ²²	2023

**Exhibit 1: The Independence at Home Demonstration,
A Table Review of the Literature—Continued**

Title	Authors	Publication/Link	Year
Continuing Need for and Disparities in Access to Home-Based Care			
Geographic Concentration of Home-Based Medical Care Providers	Nengliang Yao et al.	35 Health Affairs ²³	2016
Home-Based Medical Care Use in Medicare Advantage and Traditional Medicare in 2018	Jeffrey Marr et al.	42 Health Affairs ²⁴	2023
County-Level Social Vulnerability, Metropolitan Status, and Availability of Home Health Services	Harriet Mather, Katherine A. Ornstein, & Catherine McDonough	JAMA Open Network ²⁵	2023
The Dynamics of Being Homebound Over Time: A Prospective Study of Medicare Beneficiaries	Claire K. Ankuda et al.	69 J. Am. Geriatrics Soc'y ²⁶	2021

- ¹ <https://agsjournals.onlinelibrary.wiley.com/doi/pdf/10.1111/jgs.12974>.
² <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.13030>.
³ <https://jamanetwork.com/journals/jama/fullarticle/209717>.
⁴ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.18386>.
⁵ <https://www.mathematica.org/publications/evaluation-of-the-independence-at-home-demonstration-an-examination-of-year-7-the-first-year>.
⁶ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.18656>.
⁷ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.18659>.
⁸ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17426>.
⁹ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17640>.
¹⁰ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17641>.
¹¹ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.15968>.
¹² <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17999>.
¹³ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.18153>.
¹⁴ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.15314>.
¹⁵ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.14176>.
¹⁶ https://academic.oup.com/innovateage/article/1/suppl_1/1328/3902111?login=false.
¹⁷ <https://www.healthaffairs.org/content/forefront/strengthen-primary-care-first-model-most-frail-look-independence-home-demonstration>.
¹⁸ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.13088>.
¹⁹ https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/home-based-care_research.pdf.
²⁰ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17365>.
²¹ https://link.springer.com/chapter/10.1007/978-3-319-61329-1_11.
²² <https://pubmed.ncbi.nlm.nih.gov/37084771/>.
²³ https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1437?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%20pubmed.
²⁴ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00376>.
²⁵ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2810650>.
²⁶ <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.17086>.

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Dear Chairman Wyden and Ranking Member Crapo:

The American Academy of Ophthalmology appreciates the opportunity to share our perspectives on bolstering chronic care through Medicare physician payment. Ophthalmologists regularly treat numerous chronic and potentially blinding eye conditions such as age-related macular degeneration, diabetic retinopathy, and glaucoma, among others. Ophthalmology practices also treat large numbers of Medicare patients and are significantly impacted by Medicare physician payment policies. We commend you for holding this timely hearing as the current Medicare physician payment system is on an unsustainable path at a time when physicians are providing more care with fewer resources to maintain their practices as they manage patients in an increasingly complex health care environment. Without Congressional action, physicians will again be facing Medicare payment cuts in 2025, which could negatively impact Medicare beneficiaries' timely access to the health care they need.

The Academy is the largest association of eye physicians and surgeons in the United States. A nationwide community of nearly 22,000 medical doctors, we protect sight

and empower lives by setting the standard for ophthalmic education and advocating for our patients and the public. We innovate to advance our profession and to ensure the delivery of the highest-quality eye care. As such, we stand ready to work with the Committee and Congress to develop long-term solutions to the systemic problems within the Medicare physician payment system and preserve patient access to the highest-quality eye care.

Our recommendations for long-term reform are listed below. We look forward to working with you on the implementation of these needed changes.

Annual Inflation-Based Payment Update:

When looking at the data, physician payments have fallen far behind inflation and increasing practice costs. In the past 22 years, Medicare physician payments have only seen a modest increase of 9 percent, averaging just 0.4 percent per year. Meanwhile, the expenses associated with running a medical practice have surged by 47 percent from 2001 to 2023. Adjusted for inflation's impact on practice costs, Medicare physician pay has declined 26 percent during the same period (2001 to 2023). This impact is unique to physician payments as nearly all other Medicare providers and suppliers receive an annual inflationary payment update. With this significant decline in real value of allowed charges, financial challenges have disproportionately impacted small, independent, and rural physicians, which incentivizes market consolidation and practice closures.¹

As the Senate Committee on Finance continues work to address the broken Medicare physician payment system, we urge the Committee to support legislation which would provide an annual inflation-based payment update based on the full Medicare Economic Index (MEI). A full inflation-based update would be a critical step towards resolving the problems created by ongoing yearly payment cuts that are plaguing our healthcare system and would help provide long fiscal stability for physicians.

Budget Neutrality:

Another key factor to consider addressing is the mandated budget neutrality requirement in the Medicare Physician Fee Schedule. By law, Medicare is a budget neutral financing system for physician reimbursements. Any positive payment adjustments for those who exceed the performance threshold are paid for by those receiving penalties. In the early years of the program, it was possible to avoid a penalty because the performance threshold was understandably set low as eligible providers grew familiar with the new program. As expected, the positive payment adjustments were small because most participants were not getting a penalty. Fortunately, during these early years Congress set aside a pool of money to be split among the exceptional performers who exceeded the performance threshold. This provided at least a small incentive to adopt meaningful changes to support high-quality care.

Though the performance threshold has been raised year over year, the budget-neutral nature of the bonus payment adjustments continues to suppress the Congressionally intended meaningful positive payment incentives that can be realized. An article in *Ophthalmology*² reviewed the national allowable payments for 13 of the 15 commonly performed ophthalmology procedures from 2011 to 2020, documenting a significant 6.2% decline in reimbursement. The decline is a 17.7% cut when adjusted for inflation. While some reductions were due to revaluing misvalued codes, this study shows that the statutorily mandated budget neutrality requirement is forcing CMS to undervalue ophthalmology and other surgical services in the absence of legislation to enlarge the physician payment pool. As such, we urge the Committee to address the budget neutrality requirement. **Therefore, the Academy strongly recommends that Congress enact reforms to the budget-neutrality policies of the Medicare Physician Fee Schedule to reduce inappropriate payment cuts and provide stability for Medicare physician payments.**

¹Kaiser Family Foundation. What We Know About Provider Consolidation. September 2, 2020. <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>. Accessed June 15, 2023.

²Patel S, Glasser D, Repka M, Berkowitz S, Sternberg P. Changes in Medicare Reimbursement for Commonly Performed Ophthalmic Procedures. *Ophthalmology* 2021. doi:10.1016/j.ophtha.2021.02.026. [https://www.aaojournal.org/article/S0161-6420\(21\)00194-9/fulltext](https://www.aaojournal.org/article/S0161-6420(21)00194-9/fulltext).

Global Surgical Code Payments:

Medicare currently pays surgeons and other specialists a single fee (global payment) when they perform major or minor surgery such as brain tumor removal, joint replacement, heart surgery, or cataract surgery. CMS established these global payments to cover the costs of a procedure, plus the typical pre-operative and follow-up care needed within a 10- or 90-day post-operative timeframe. Postop visits require the same physician work, medical decision making, and practice expenses as office E/M visits. Patient complexity does not disappear during the post-operative global period. In contrast, it is not unusual for surgery to destabilize comorbid conditions for patients with systemic conditions such as diabetes, hypertension, or glaucoma, that were stable prior to surgery. Surgeons, therefore, must also consider the complexity of problems and complications and/or morbidity or mortality of patient management just as they would do for a standalone E/M visit.

In 2021, CMS increased payment for E/M services. However, the agency did not apply these increases to post-operative visits included in global surgical codes. The expense and complexity of these visits has increased just as those visits outside of the surgical global period. Despite engagement efforts by the Academy, the American Medical Association, the American College of Surgeons and others, CMS again declined to apply the increased E/M values to post-operative visits in both the 2023 and 2024 Medicare Physician Fee Schedules.

Arbitrarily adjusting certain E/M codes in the Fee Schedule conflicts with the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Public Law 101-239), which prohibits Medicare from paying physicians differently for the same work. Failing to adjust payment for E/M visits included in global codes results in paying surgeons less than other physicians, *in violation of the law*. Every time CMS has increased payment for office visits in the past, the agency also adjusted global surgery bundled payments to account for the E/M portion of these codes.

Ophthalmology services, such as the recently revalued retinal detachment surgery, demonstrate why the current policy creates inequity. Surgeons now receive LESS pay for the work of a retinal detachment procedure AND the two post-operative visits, than if the surgeon did the procedure for free, and *only* billed for the two post-operative visits at the current rate for E/M office visits. This is illogical and emphasizes why CMS' policy must change.

One reason CMS uses to justify undervaluing surgical E/M visits, is that the agency is not convinced surgeons provide all the post-operative visits included in global surgical codes. However, a process already exists through the American Medical Association's Relative Value Scale Update Committee (RUC) to evaluate any global codes believed to be "misvalued" including the number of postoperative visits. The adjustment of cataract surgery fees show how the process ensures codes are appropriately valued.

CMS revalued cataract surgery payment through this medicine-supported process in 2019. Since CMS accepted the RUC's recommended revaluation, including that ophthalmologists provide three post-operative visits in the procedure's 90-day global period, these doctors should be paid equally to other physicians for providing the same level of service per patient. **The Academy continues working with other surgical organizations to have CMS revisit its decision and apply the increased values to the E/M portion of the global codes. The Academy urges the Committee to put additional pressure on the agency to provide proper equitable payment for postoperative E/M visits included in global surgical packages.**

Payment Challenges and Healthcare Consolidation:

Historically, ophthalmology practices have been small businesses with more than 90% of our members in small practices, defined by Medicare as having 15 or fewer physicians. However, medical practice consolidation including ophthalmology has increased significantly in recent years.³ While ophthalmology had largely escaped hospital and health system practice acquisitions in the past, the specialty is now experiencing a trend in private equity consolidation.

Looking at consolidation more broadly across medicine, an AMA report stated that 2020 was the first year when less than half (49.1%) of patient care physicians

³Chen E, Cox J, Begaj T, Armstrong G, Khurana R, Parikh R. Private Equity in Ophthalmology and Optometry. *Ophthalmology*. 2020;127(4):445-455. doi:10.1016/j.ophtha.2020.01.007. [https://www.aaojournal.org/article/S0161-6420\(20\)30012-9/fulltext](https://www.aaojournal.org/article/S0161-6420(20)30012-9/fulltext). Published 2020.

worked in a private practice. The report also noted that the decrease in private practice physicians appears to have accelerated in recent years.⁴

The Academy is concerned about what greater consolidation within medicine could mean for patient care. While private equity has a diversity of forms, some of our members are troubled that private equity consolidation is prioritizing profit over patient care through understaffing and incentivizing unnecessary procedures. Consistent with these concerns, the Medicare Payment Advisory Commission's (MedPAC) March 2021 report stated that hospitals and physician groups were driving up prices as they consolidated.⁵

As one of the primary physician specialties caring for Medicare beneficiaries, we support the oversight of Medicare spending. The Academy strongly believes the lack of fair updates to the Medicare Physician Fee Schedule is a major contributing factor to the consolidation trend. **We believe Congress should review the current incentives to consolidate to ensure that Medicare policies are not inadvertently contributing to the drive towards greater consolidation of medical practices.**

Administrative Burdens on Physician Practices:

Another aspect impacting the delivery of care is administrative and financial burdens dealing with prior authorization, which impose a significant strain on physicians and the patients they treat. Obtaining pre-approval for medical treatments or tests before administering care to their patients is a time-consuming and costly procedure that often forces physicians and their staff to spend a significant portion of their week engaging in negotiations with insurance companies. In most cases the care is ultimately approved. This time would be better utilized in caring for patients.

The practice of prior authorization is rampant, and in 2018, the Office of the Inspector General (OIG) conducted a study that revealed an alarming trend in Medicare Advantage (MA) plans. It was found that MA plans overturned 75% of their own denials, strongly suggesting that the prior authorization process significantly delays medically necessary care. Furthermore, a more recent analysis conducted by the OIG demonstrated that the use of prior authorization by MA plans has led to the denial of medically necessary care that would have been covered under Medicare Fee-For-Service (FFS) for beneficiaries.

The Academy has heard from many ophthalmologists, especially retina specialists, that some MA plans are requiring prior authorization for each visit and each intravitreal injection used to treat age-related macular degeneration (AMD), a chronic condition that requires monthly treatment in many patients. When asked, these retina specialists report that MA plans are approving essentially 100% of their prior authorization requests for this service. This continued prior authorization requirements are daily care and add additional cost.

The Academy urges the Committee to support legislation that establishes an electronic prior authorization (e-PA) program within Medicare Advantage (MA), and also require MA plans to provide real-time decision making when responding to requests for items and services. By implementing an e-PA program and ensuring timely decisions, Congress can help streamline the prior authorization process, reduce administrative burdens, decrease pressure for consolidation, and improve access to necessary care and services for patients.

Conclusion:

The Academy applauds the Committee for conducting this hearing in order to develop policies that will improve physician payment and increase access to care for patients across the United States. We stand ready to work with the Committee and provide feedback as you pursue future policy changes.

⁴ Kane C. Policy Research Perspectives: Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020. *Ama-assn.org*. <https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf>. Published 2021.

⁵ Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. 2021:xiv. http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf?sfvrsn=0.

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AAOS Recommendations: A Specialty Care Reimbursement Model to Operationalize Value-based Care for Musculoskeletal Conditions

Prepared and Reviewed by AAOS Healthcare Systems Committee

Karl M. Koenig, Chair

A. Executive Summary

In response to the Center for Medicare and Medicaid Innovation (CMMI) initiatives in the space of value-based payment reform, the American Academy of Orthopaedic Surgeons (AAOS) and physician leaders have worked closely to develop recommendations toward advancing high value orthopaedic payment and practice models. With the end goal of moving away from dominant traditional fee-for-service models, the most prolific step to date is the sharing of risk on the total cost of care with health systems through accountable care organizations (ACOs). Building on this foundation, the challenge then remains to develop a structure by which ACOs and primary care providers can interact with musculoskeletal specialists and teams in a meaningful way. This can be achieved by creating opportunities to reward the practice of evidence-based, high value, cost-efficient care for patients.

ACOs have matured at the primary care level, and many are on the road to improving quality of care for their populations through enhanced coordination and comprehensive chronic and complex disease management while sharing savings and lowering costs. However, ACOs still face challenges when it comes to organizational transformation around specialty care. At the specialty level, procedure-based bundled episode payment models, such as those involving total joint replacement surgery for osteoarthritis (OA) of the hip or knee, have been met with limited success. Cost reductions have been achieved through reductions in utilization (*e.g.*, post-acute care), while maintaining but not substantially improving, clinical outcomes. Ultimately such models were never directly configured to address procedural appropriateness, or the provision of timely, equitable, and comprehensive specialized care, nor tailored to meet the holistic needs of diverse populations with a view to improving their health outcomes more broadly. In essence, the goal of true value for patients with specialized conditions has yet to be realized.

Momentum is building among stakeholders in health care to shift the status quo toward a whole person approach that considers the patient's condition alongside their preferences, values, and needs (characterized as "Comprehensive Condition-Based Care"). This shift promises to support and incentivize the reorganization of musculoskeletal care into multidisciplinary teams that aim to deliver more coordinated and efficient management of conditions across the full cycle of care. Most health systems currently perform "non-operative care" on the backdrop of primary care providers with insufficient support systems and/or training in managing musculoskeletal conditions. This often leads to a myriad of unnecessary imaging studies, non-value-added interventions, and delays to patient care. Once the PCP has exhausted their capabilities in caring for a particular condition, they are expected to navigate a broad portfolio of specialists and subspecialists who are all working under different sets of incentives and payment infrastructures. One logical approach to solving this issue is to incentivize care through condition-based payments with the aim of driving reorganization and model redesign on the specialty front. The end goal for ACOs would be early referral of these patients into the sphere of efficient, high quality specialty care teams without a concern that such patients will immediately become "high cost," but instead confidence that they will receive high value care.

In a comprehensive condition-based payment, a team of providers is paid a contracted rate to provide all care for a specified medical condition (or set of conditions) while holding themselves accountable to outcome measures relevant to that condition. The team is therefore incentivized to deliver high-value care throughout the entire cycle of the condition, including appropriate decision-making around when to proceed with surgical or non-surgical interventions. Such a system offers multiple

positive effects on the delivery of care for musculoskeletal conditions. During our time conceptualizing value-based payment reform initiatives, as “The Consortium for the Next Generation of Alternative Payment Models,” we have identified a comprehensive set of considerations for condition-based care that should be addressed by stakeholders attempting to collaboratively build such models. These considerations have been framed as a design process of discovering the nature, scale, and opportunity; defining an analytical approach; developing model specifications fit for practice; and delivering the transformation.

B. Discovery: Discovering the Nature, Scale, and Opportunity

Stakeholders should get a sense of the nature, scale, and opportunity (clinical, financial, and experiential) of a new business model centered on a high value condition-based payment program. A first step is to define who is going to participate in building the most effective program before understanding how a new program fits among competing priorities within the organization and appreciating the potential challenges faced in specifying and building the requirements for such a program.

Who is Going to Participate and How?

Multiple stakeholders—whether payer, provider, or vendor—can spark the transformation toward high value musculoskeletal care and should remain steadfast in motivating others to join forces. Orthopaedic surgeons must be at the forefront of this change and either lead or be heavily involved with these teams because we have the highest level of training and often provide the full breadth of evidence-based treatment options for a given musculoskeletal condition. Expertise in the full spectrum of treatments allows the team to reduce unnecessary diagnostic testing that does not change treatment, reduces non-value-added interventions for patients, and provides timely evaluation and intervention when surgical treatment is the best answer. Having the full suite of evidence-based options catalyzes efficiency across the system and maximizes value from the patient perspective (which is our primary goal).

A team delivering condition-based care must have “all the tools in their toolbox” to avoid unnecessary delays in access and treatment. Depending on the condition, the clinical team structure may vary and includes a multitude of musculoskeletal providers such as Orthopaedic surgeons, rheumatologists, primary care sports medicine specialists, physical therapists, physiatrists, associate providers, podiatrists, chiropractors, prosthetist/orthotists, dieticians and mental health providers.

Should our team participate? Gaining a broader understanding of participating entities across the stakeholder groups and the base configuration of the contracting arrangement will enable the design of a program that is fit for purpose. Are we confident we will collectively have the people, resources, creativity, and capabilities to successfully implement condition-based care and most importantly the belief that this is ultimately better care? If not, then working with another entity to convene and manage comprehensive, condition-based payments on a larger scale may be the best entry point.

Scoping Exercise

We recommend an initial scoping exercise to concretely identify the affected patient population, geographical distribution, key stakeholders/service providers, affected membership count (including identified payer segments), and estimate of medical expenses for affected members. The most obvious candidates for a Medicare population would be “Knee Pain/Knee Osteoarthritis” or “Low Back Pain/Degeneration.” Given the previous experience with procedure bundles in these conditions, prior experience can facilitate the genesis of a pilot program.

Clear gaps and opportunities for improvement should be articulated, such as sub-optimal utilization, deficiencies in existing care pathways, outcomes assessed, issues of access and health equity, and affordability of care.

C. Definition: Defining an Analytical Approach and Assumptions

It is important to define an analytical approach and set expectations on analytical outputs early as part of the cycle of evidence generation that will fuel program configuration, implementation, and scaling. From this point onward, we illustrate recommendations and a framework with the management of knee pain/knee osteoarthritis in general (secondary to degenerative joint disease). Ideally, this phase should also accompany an actuarial model of the targeted population to identify reasonable financial constructs and targets.

1. Condition Scope
Knee pain, degeneration, and derangement – Osteoarthritis – Meniscal tear
2. Condition Scope—Exclusions
Exclude – Malignancy (primary or metastatic) – Post-traumatic Arthritis (Motor vehicle accidents, trauma, intra-articular fracture) – Autoimmune arthrosis (<i>e.g.</i>, Rheumatoid arthritis, lupus) or other inflammation
3. Diagnostic Coding
Global MSK codes (ICD–10)—the partnership intent is to effectively capture all relevant MSK diagnoses together (<i>e.g.</i>, Knee Osteoarthritis (side specific), Mensical Tear, Sprain/Strain, etc). (See Appendix) A separate consideration is to include pain diagnoses that are later confirmed with an Eligible MSK Diagnosis. (<i>e.g.</i>, member diagnosed with knee OA, but presented with knee pain 2 months prior—therefore, include all related Knee Pain services during that 2-month interim period). Such relevant services for pain episodes that lead to a diagnosed clinical condition (<i>e.g.</i>, E&M, imaging, rehabilitation) could reasonably be included for maintaining accountability.
4. Service Scope
Type of service (some or all) 1. All related E&M codes for musculoskeletal providers 2. Specific CPT codes (<i>e.g.</i>, surgery, physical therapy, anesthesia) 3. Capture but “bucket” lower value interventions (<i>e.g.</i>, MRI, hyaluronic acid, arthroscopy) Geographic 1. ZIP code/county level 2. State level 3. MSA level 4. Other strategic level Place of service (some or all) 1. Inpatient 2. Outpatient 3. Office 4. Ambulatory Surgical Center (ASC) 5. ED Illustration Include all CPT codes that evidence an eligible diagnosis (defined earlier by Scope considerations) within a prespecified claim level (<i>e.g.</i>, first four positions), at any Place of Service, in as wide a geography as feasible. More is better to create critical mass for clinicians, patients, and finances (practice revenue potential, medical expense savings potential; spread out fixed costs for everyone for this transformation). (See Appendix H).
5. Performance Evaluation
Performance Start-Stop 1. Performance Year—predefined 12-month period wherein APM eligibility, attribution, and accountability are adjudicated. Most obvious is calendar year (January 1–December 31). 2. Episode basis—member-specific starting date when initial eligible diagnosis/Trigger starts. Unique for each member (<i>e.g.</i>, one member on March 13th, another on April 3rd, etc) Duration of Performance 1. 90 days 2. 6 months 3. 12 months Illustration 12-month performance year on a calendar year basis with 90 day and 6-month evaluations

Outcomes Reporting:

1. Patient-reported Pain/Function: participation requires the incorporation of knee specific PRO scores and aggregate reporting at 6 months and 12 months (for accountability rather than comparison across participants). KOOS JR is currently used most broadly.
2. Clinical: Utilize current clinical outcome metrics reporting for surgical patients (re-admissions, reoperations)

Define and Communicate Savings Assumptions

Based upon the analytical approach and analytical outputs, the participating service provider(s) should be able to use the data to specify a) where they identify the opportunity, b) how they approach that identified opportunity in their service delivery configuration, and c) the projected magnitude of impact on outcomes related to quality, finances, and/or experience.

For example, illustrative opportunities in musculoskeletal care are shown in the table below where impact can be generated around utilization (increase high value and decrease low value strategies), intensity (reduce the intensity of utilization of specific strategies), locus of services (shift the location of services to enable more convenience, quality, experience while reducing cost).

Opportunity Area	Approach	Projected area/magnitude of Impact
Injections	Reduce utilization (<i>e.g.</i> , hyaluronic acid) and reduce intensity (<i>e.g.</i> , steroid)	Financial
Advanced Imaging	Reduce utilization (<i>e.g.</i> , MRI) and reduce intensity (<i>e.g.</i> , Frequency of x-rays)	Financial
Rehabilitation	Shift locus of services to self-management at home; Reduce utilization of post-acute care; Increase utilization of exercise therapy, education, and self-management	Financial/Quality/Experience
Pain education and behavioral health management	Increase assessments of mental/behavioral health, train in coping strategies, health coaching, psychological interventions	Financial/Quality/Experience
Overall visits	Reduce number of outpatient visits	Financial/Experience
Surgery	Reduce inappropriate surgical utilization and increase appropriate surgical selection through shared decision-making	Financial/Quality/Experience

Broad statements of savings assumptions *e.g.*, “15% savings on musculoskeletal-related costs” should be validated and articulated lever-by-lever by both payer and provider, including actuarial associates from each. These assumptions should be founded upon the payer’s actual membership population and the provider’s current or desired-future membership reach, as well as incorporate program engagement assumptions, *e.g.*, 15% savings on 10% engaged members in a given year over 100,000 lives by specific geographies.

C. Develop

Program Pricing
Key Q. What should the episode price be inclusive of and what are withholding criteria? Key Points. The price is inclusive of: – Historical per-patient annual spend on relevant services (according to the program specifications regarding included ICD-10s, CPTs, sites, types, provider, geographies, lines of business, etc.)
MSK Illustration Include surgical professional fee distributed across all patients as fraction of utilization rate (<i>e.g.</i>, \$1,000 fee, 15% utilization rate = \$150 added to each per-member per-period payment) – For the related-but-separate surgical bundle, there will exist a separate target price (less the surgical professional fee) Apply withholds for 1) episode completion/attribution and 2) quality measurement Balance provider-specific and multi-provider/regional utilization history Also need to include correction for under-utilization of relevant services (<i>e.g.</i>, nutrition, mental health)
Type and Level of Risk
Key Q. What are the key considerations around type and level of risk? Key Points. Likely begin with initial upside for 1–2 years, introduce downside years 2–3 and beyond, moving eventually toward risk-adjusted capitated payment. Scope of risk to be defined by Program Parameters (diagnosis, service, site, type, provider, geography, etc.).

D. Delivery: Delivering the Transformation

With the incentive of appropriate condition-based payments as an organizing principle, a variety of different structures will be viable. Time and experience will yield the most efficient structures and the system will adjust appropriately.

Multidisciplinary MSK Practices: Many such practices currently exist who could take on a condition-based payment structure with minimal investment and adjustment. Often created by the expansion of Orthopaedic surgery groups, there are many examples of teams that already include Rheumatology, PMNR, Primary Care Sports, Physical Therapy, Podiatry, and Prosthetists/Orthotists. Such groups will be poised to take on pilot programs and prove the concept in conjunction with CMS. Internal reorganization will be required for many, but new capital investment and hiring could be minimized.

Fully integrated health systems: Broad Solutions engage with both providers and members to improve care delivery and assume deep global/total accountability for cost and quality. For members they may offer care management, navigation, education, and other virtual or in-person services. For providers they may offer service line management, care pathways, incentive structures, ancillary services.

Role of Market-based and digital health solutions:

Utilization management solutions can be denial or education-based to enable provider (and member) adherence to clinical practice guidelines. These entities can provide immediate value but may also trigger some friction with the provider community. Such solutions could be used to stimulate accountable entities to perform and/or accept substantial risk to dial down the utilization management, or even turn it off.

Point Solutions have rapidly expanded with a laser-focus on member experience and the delivery of coordinated, continuous, and convenient care for patients both in-person and through virtual care. Such solutions can provide relatively immediate value for health plans and accountable entities, with return on investment (ROI) guarantees. However, point solution coordination and integration with traditional provider networks is generally lacking at this time. In order to provide the full spectrum of care and take on a condition-based payment, these entities will need to partner with existing providers. This is another method of organization that will “naturally” create new entities and enable participation by smaller independent providers and practice groups.

**Appendix: Included ICD-10 Codes for “Knee Pain/Knee Osteoarthritis”
for Medicare Patients**

M13861	Lower Extremity	Other specified arthritis, right knee
M13862	Lower Extremity	Other specified arthritis, left knee
M170	Lower Extremity	Bilateral primary osteoarthritis of knee
M1711	Lower Extremity	Unilateral primary osteoarthritis, right knee
M1712	Lower Extremity	Unilateral primary osteoarthritis, left knee
M1712	Lower Extremity	Unilateral primary osteoarthritis, left knee
M1712	Lower Extremity	Unilateral primary osteoarthritis, left knee
M174	Lower Extremity	Other bilateral secondary osteoarthritis of knee
M222X1	Lower Extremity	Patellofemoral disorders, right knee
M2241	Lower Extremity	Chondromalacia patellae, right knee
M23051	Lower Extremity	Cystic meniscus, posterior horn of lat mense, right knee
M2341	Lower Extremity	Loose body in knee, right knee
M2341	Lower Extremity	Loose body in knee, right knee
M2341	Lower Extremity	Loose body in knee, right knee
M238X9	Lower Extremity	Other internal derangements of unspecified knee
M2392	Lower Extremity	Unspecified internal derangement of left knee
M24661	Lower Extremity	Ankylosis, right knee
M25462	Lower Extremity	Effusion, left knee
M25561	Lower Extremity	Pain in right knee
M25562	Lower Extremity	Pain in left knee
M67461	Lower Extremity	Ganglion, right knee
M7041	Lower Extremity	Prepatellar bursitis, right knee
M7121	Lower Extremity	Synovial cyst of popliteal space [Baker], right knee
M7122	Lower Extremity	Synovial cyst of popliteal space [Baker], left knee
M7122	Lower Extremity	Synovial cyst of popliteal space [Baker], left knee
M7651	Lower Extremity	Patellar tendinitis, right knee
M93261	Lower Extremity	Osteochondritis dissecans, right knee
M9689	Lower Extremity	Oth intraop and postproc comp and disorders of the ms sys

Q686	Lower Extremity	Discoid meniscus
S8001XD	Lower Extremity	Contusion of right knee, subsequent encounter
S83004A	Lower Extremity	Unspecified dislocation of right patella, initial encounter
S83004D	Lower Extremity	Unspecified dislocation of right patella, subsequent encounter
S83200D	Lower Extremity	Bucket-handle tear of unsp meniscus, current injury, right knee, subsequent encounter
S83206A	Lower Extremity	Unsp tear of unsp meniscus, current injury, right knee, initial encounter
S83206D	Lower Extremity	Unsp tear of unsp meniscus, current injury, right knee, subsequent encounter
S83207A	Lower Extremity	Unsp tear of unsp meniscus, current injury, left knee, initial encounter
S83207D	Lower Extremity	Unsp tear of unsp meniscus, current injury, left knee, subsequent encounter
S83207S	Lower Extremity	Unsp tear of unsp meniscus, current injury, left knee, sequela
S83209A	Lower Extremity	Unsp tear of unsp meniscus, current injury, unsp knee, initial encounter
S83209D	Lower Extremity	Unsp tear of unsp meniscus, current injury, unsp knee, subsequent encounter
S83221D	Lower Extremity	Partial tear of medial meniscus, current injury, right knee, subsequent encounter
S83222D	Lower Extremity	Partial tear of medial meniscus, current injury, left knee, subsequent encounter
S83231A	Lower Extremity	Complex tear of medial meniscus, current injury, right knee, initial encounter
S83231D	Lower Extremity	Complex tear of medial meniscus, current injury, right knee, subsequent encounter
S83232D	Lower Extremity	Complex tear of medial meniscus, current injury, left knee, subsequent encounter
S83241D	Lower Extremity	Other tear of medial meniscus, current injury, right knee, subsequent encounter
S83242D	Lower Extremity	Other tear of medial meniscus, current injury, left knee, subsequent encounter
S83251A	Lower Extremity	Bucket-handle tear of lat meniscus, current injury, right knee, initial encounter
S83251D	Lower Extremity	Bucket-handle tear of lat meniscus, current injury, right knee, subsequent encounter
S83261A	Lower Extremity	Partial tear of lat meniscus, current injury, right knee, initial encounter
S83261D	Lower Extremity	Partial tear of lat meniscus, current injury, right knee, subsequent encounter

S83271A	Lower Extremity	Complex tear of lat mense, current injury, right knee, init
S83281D	Lower Extremity	Oth tear of lat mense, current injury, right knee, subs
S83411A	Lower Extremity	Sprain of medial collateral ligament of right knee, init
S83412A	Lower Extremity	Sprain of medial collateral ligament of left knee, init
S83422A	Lower Extremity	Sprain of lateral collateral ligament of left knee, init
S83521A	Lower Extremity	Sprain of posterior cruciate ligament of right knee, init
S838X2A	Lower Extremity	Sprain of other specified parts of left knee, init encntr
S8391XA	Lower Extremity	Sprain of unspecified site of right knee, initial encounter
S8392XA	Lower Extremity	Sprain of unspecified site of left knee, initial encounter
Z96651	Lower Extremity	Presence of right artificial knee joint
Z96652	Lower Extremity	Presence of left artificial knee joint
Z96653	Lower Extremity	Presence of artificial knee joint, bilateral
Z96659	Lower Extremity	Presence of unspecified artificial knee joint
M1710	Lower Extremity	Unilateral primary osteoarthritis, unspecified knee
M175	Lower Extremity	Other unilateral secondary osteoarthritis of knee
M179	Lower Extremity	Osteoarthritis of knee, unspecified
M179	Lower Extremity	Osteoarthritis of knee, unspecified
M179	Lower Extremity	Osteoarthritis of knee, unspecified
M25569	Lower Extremity	Pain in unspecified knee
M25569	Lower Extremity	Pain in unspecified knee
M11269	Lower Extremity	Other chondrocalcinosis, unspecified knee
M13169	Lower Extremity	Monoarthritis, not elsewhere classified, unspecified knee
M25469	Lower Extremity	Effusion, unspecified knee
M25669	Lower Extremity	Stiffness of unspecified knee, not elsewhere classified
M67469	Lower Extremity	Ganglion, unspecified knee
M2212	Lower Extremity	Recurrent subluxation of patella, left knee
M222X2	Lower Extremity	Patellofemoral disorders, left knee
M222X9	Lower Extremity	Patellofemoral disorders, unspecified knee

M2240	Lower Extremity	Chondromalacia patellae, unspecified knee
M2242	Lower Extremity	Chondromalacia patellae, left knee
M23222	Lower Extremity	Derang of post horn of medial mensc d/t old tear/inj, l knee
M23322	Lower Extremity	Oth meniscus derang, post horn of medial meniscus, l knee
M2342	Lower Extremity	Loose body in knee, left knee
M2351	Lower Extremity	Chronic instability of knee, right knee
M23612	Lower Extremity	Oth spon disrupt of anterior cruciate ligament of left knee
M25369	Lower Extremity	Other instability, unspecified knee
M6751	Lower Extremity	Plica syndrome, right knee
M6752	Lower Extremity	Plica syndrome, left knee
M71569	Lower Extremity	Other bursitis, not elsewhere classified, unspecified knee
S76111A	Lower Extremity	Strain of right quadriceps muscle, fascia and tendon, init
S83005A	Lower Extremity	Unspecified dislocation of left patella, initial encounter
S83005S	Lower Extremity	Unspecified dislocation of left patella, sequela
S83015D	Lower Extremity	Lateral dislocation of left patella, subsequent encounter
S83203D	Lower Extremity	Oth tear of unsp meniscus, current injury, right knee, subs
S83204D	Lower Extremity	Oth tear of unsp meniscus, current injury, left knee, subs
S83221A	Lower Extremity	Prph tear of medial meniscus, current injury, r knee, init
S83222A	Lower Extremity	Prph tear of medial meniscus, current injury, l knee, init
S83222S	Lower Extremity	Prph tear of medial mensc, current injury, l knee, sequela
S83241A	Lower Extremity	Oth tear of medial meniscus, current injury, r knee, init
S83242A	Lower Extremity	Oth tear of medial meniscus, current injury, left knee, init
S83262D	Lower Extremity	Prph tear of lat mensc, current injury, left knee, subs
S83281A	Lower Extremity	Oth tear of lat mensc, current injury, right knee, init
S83412D	Lower Extremity	Sprain of medial collateral ligament of left knee, subs

S83412S	Lower Extremity	Sprain of medial collateral ligament of left knee, sequela
S83511A	Lower Extremity	Sprain of anterior cruciate ligament of right knee, init
S83511D	Lower Extremity	Sprain of anterior cruciate ligament of right knee, subs
S83511S	Lower Extremity	Sprain of anterior cruciate ligament of right knee, sequela
S83512A	Lower Extremity	Sprain of anterior cruciate ligament of left knee, init
S83512D	Lower Extremity	Sprain of anterior cruciate ligament of left knee, subs
S83521D	Lower Extremity	Sprain of posterior cruciate ligament of right knee, subs

Appendix: Included E&M, CPT, and Services

20610	Arthrocentesis, Aspiration and/or Injection; Major Joint or Bursa (<i>e.g.</i> , Shoulder, Hip, Knee Joint, Subacromial Bursa);
20611	Arthrocentesis, Aspiration and/or Injection, Major Joint Or Bursa (<i>e.g.</i> , Shoulder, Hip, Knee, Subacromial Bursa); With Ultrasound Guidance, With Permanent Recording and Reporting
20680	Removal of Implant; Deep (<i>e.g.</i> , Buried Wire, Pin, Screw, Metal Band, Nail, Rod or Plate)
27327	Excision, Tumor, Soft Tissue of Thigh or Knee Area, Subcutaneous; Less Than 3 Cm
27347	Excision of Lesion of Meniscus or Capsule (<i>e.g.</i> , Cyst, Ganglion), Knee
27438	Arthroplasty, patella; with prosthesis
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27447	Arthroplasty, Knee, Condyle And Plateau; Medial and Lateral Compartments With or Without Patella Resurfacing (Total Knee Arthroplasty)
29505	Application Of Long Leg Splint (Thigh To Ankle Or Toes)
29874	Arthroscopy, Knee, Surgical; For Removal Of Loose Body Or Foreign Body (<i>e.g.</i> , Osteochondritis Dissecans Fragmentation, Chondral Fragmentation)
29875	Arthroscopy, Knee, Surgical; Synovectomy, Limited (<i>e.g.</i> , Plica Or Shelf Resection) (Separate Procedure)
29876	Arthroscopy, Knee, Surgical; Synovectomy, Major, 2 Or More Compartments (<i>e.g.</i> , Medial Or Lateral)
29877	Arthroscopy, Knee, Surgical; Debridement/Shaving of Articular Cartilage (Chondroplasty)
29879	Arthroscopy, Knee, Surgical; Abrasion Arthroplasty (Includes Chondroplasty Where Necessary) Or Multiple Drilling Or Microfracture
29880	Arthroscopy, Knee, Surgical; With Meniscectomy (Medial And Lateral, Including Any Meniscal Shaving) Including Debridement/Shaving of Articular Cartilage (Chondroplasty), Same or Separate Compartment(S), When Performed

29881	Arthroscopy, Knee, Surgical; With Meniscectomy (Medial or Lateral, Including Any Meniscal Shaving) Including Debridement/Shaving of Articular Cartilage (Chondroplasty), Same or Separate Compartment(s), When Performed
73552	Radiologic Examination, Femur; Minimum 2 Views
73560,TC	Radiologic Examination, Knee; 1 or 2 Views
73560	Radiologic Examination, Knee; 1 or 2 Views
73562,TC	Radiologic Examination, Knee; 3 Views
73562	Radiologic Examination, Knee; 3 Views
73564	Radiologic Examination, Knee; Complete, 4 Or More Views
73565,TC	Radiologic Examination, Knee; Both Knees, Standing, Anteroposterior
73565	Radiologic Examination, Knee; Both Knees, Standing, Anteroposterior
73590	Radiologic Examination; Tibia And Fibula, 2 Views
73721	MRI Knee Lt or Rt W/O Contrast
73718	MRI Lower Leg Lt or Rt W/O Contrast
73720	MRI Lower Leg Lt or Rt W/O & W/Contrast
73723	MRI Knee Lt or Rt W/O & W/Contrast
73700	CT Knee w/o IV contrast
73701	CT knee w/ IV contrast
73702	CT knee w/ and w/o IV contrast
76377	CT knee 3D postprocessing
76000,TC	Fluoroscopy (Separate Procedure), up to 1 Hour Physician or Other Qualified Health Care Professional Time, Other Than 71023 or 71034 (e.g., Cardiac Fluoroscopy)
76000	Fluoroscopy (Separate Procedure), up to 1 Hour Physician or Other Qualified Health Care Professional Time, Other Than 71023 or 71034 (e.g., Cardiac Fluoroscopy)
76882	Ultrasound, Extremity, Nonvascular, Real-Time With Image Documentation; Limited, Anatomic Specific
90832	Psychotherapy, 30 Minutes With Patient and/or Family Member
90834	Psychotherapy, 45 Minutes With Patient and/or Family Member
90837	Psychotherapy, 60 Minutes With Patient and/or Family Member
93971	Duplex Scan of Extremity Veins Including Responses to Compression and Other Maneuvers; Unilateral Or Limited Study
97110	Therapeutic Procedure, 1 or More Areas, Each 15 Minutes; Therapeutic Exercises to Develop Strength and Endurance, Range of Motion and Flexibility
97140	Manual Therapy Techniques (e.g., Mobilization/Manipulation, Manual Lymphatic Drainage, Manual Traction), 1 or More Regions, Each 15 Minutes
97161	Physical Therapy Eval Low Complex 20 Min

97162	Physical Therapy Eval Mod Complex 30 Min
99024	Postoperative Follow-Up Visit, Normally Included in the Surgical Package, to Indicate That an Evaluation and Management Service was Performed During a Postoperative Period for a Reason(s) Related To the Original Procedure
99201	Office or Other Outpatient Visit for the Evaluation and Management of a New Patient; Low Severity. Level 1
99202	Office Or Other Outpatient Visit for the Evaluation and Management of a New Patient; Low to Moderate Severity. Level 2
99203	Office or Other Outpatient Visit for the Evaluation and Management of a New Patient; Moderate Severity. Level 3
99204	Office or Other Outpatient Visit for the Evaluation and Management of a New Patient, Moderate to High Severity. Level 4
99205	Office or Other Outpatient Visit for the Evaluation and Management of a New Patient; Moderate to High Severity. Level 5
99211	Office Or Other Outpatient Visit for the Evaluation and Management of an Established Patient; Low Severity. Level 1
99212	Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient; Low to Moderate Severity. Level 2
99213	Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient; Low to Moderate Severity. Level 3
99214	Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient; Moderate to High Severity. Level 4
99215	Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient; Moderate to High Severity. Level 5
99492	First 70 Minutes in the First Calendar Month for Behavioral Health Care Manager Activities, in Consultation With a Psychiatric Consultation and Directed by the Treating Provider
99493	First 60 Minutes in a Subsequent Month for Behavioral Health Care Manager Activities
99494	Each Additional 30 Minutes in a Calendar Month of Behavioral Health Care Manager Activities
J3301	Injection, Triamcinolone Acetonide, Not Otherwise Specified, 10 mg
L1810	Knee Orthosis, Elastic With Joints, Prefabricated Item That Has Been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to fit a Specific Patient by an Individual With Expertise
L1812	Knee Orthosis, Elastic With Joints, Prefabricated, Off-The-Shelf
L1820	Knee Orthosis, Elastic With Condylar Pads and Joints, With or Without Patellar Control, Prefabricated, Includes Fitting and Adjustment
L1845	Knee Orthosis, Double Upright, Thigh and Calf, With Adjustable Flexion and Extension Trimmed, Bent, Molded, Assembled
MISCLMSW30	Lmsw Visit 30 min.
MISCLMSW45	Lmsw Visit 45 min.
MISCLMSW60	Lmsw Visit 60 min.

MISCMG30	Social Worker Meet And Greet/Cp Visit 30 min.
MISCMG45	Social Worker Meet And Greet/Cp Visit 45 min.
MISCMG60	Social Worker Meet And Greet/Cp Visit 60 min.
MISCRD30	Registered Dietitian Visit 30 min.
MISCRD45	Registered Dietitian Visit 45 min.
MISCRD60	Registered Dietitian Visit 60 min.
MISCSW	Collab Care Social Worker Non-Billable Visit
80053	Pathology & Labs
85027	Pathology & Labs
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G0502	Risk Modification
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 W: <https://www.entnet.org/>

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO—HNS), I am pleased to submit the following comments in response to the Senate Finance Committee’s hearing to examine how changes to Medicare physician payment can bolster chronic care.

The AAO—HNS is the national medical association of physicians dedicated to the care of patients with disorders of the ears, nose, and throat, as well as related structures of the head and neck. The Academy has approximately 13,000 members who provide clinical, surgical, and hospital care in rural, urban, and suburban communities. Our membership spans academic, private independent practices, and employed physicians across all practice sizes from solo to large single-specialty and multi-specialty groups, reaching into the hundreds.

Otolaryngologist—head and neck surgeons—diagnose and treat patients from conception to end of life, providing complete diagnostic, medical and surgical treatment for a wide range of medical conditions, including allergic and sinus disease, hearing and balance disorders, head and neck cancer, sleep disorders, speech and swallowing problems, cosmetic reconstructive surgery of the face and neck, acute trauma to the head and neck, and pediatric and geriatric care.

Reforming our nation’s healthcare system is a complex endeavor, and there is no one-size-fits-all solution. The AAO—HNS shares the Committee’s desire to work toward a more affordable, sustainable, and patient-centered healthcare system—particularly on ways to reduce the burden of chronic disease management in the Medicare program.

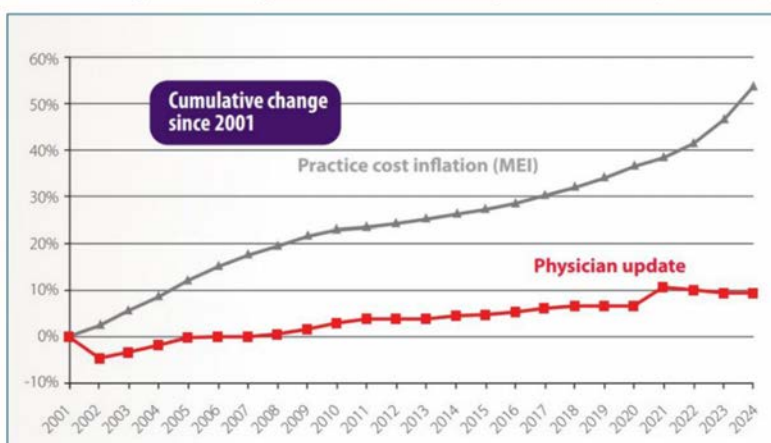
Our statement addresses the major issues affecting our members under the current Medicare physician payment system and quality improvement program. We urge the Committee to consider our recommendations (in bold), and we look forward to work-

ing together to advance policies that ensure access to comprehensive care for our patients and provide much-needed stability for physicians.

Reforming the Medicare Physician Fee Schedule

The AAO—HNS continues to be deeply alarmed about the growing financial instability of the Medicare physician payment system due to a confluence of fiscal uncertainties. For the past 4 years, physicians participating in Medicare have faced annual statutory payment cuts which come in the absence of inflationary updates. The payment system remains on an unsustainable path threatening beneficiaries' access to physicians. When adjusted for inflation, Medicare physician payment has effectively declined 29% from 2001 to 2024 (see chart below).

Medicare updates compared to inflation in practice costs (2001-2024)



Sources: Federal Register, Medicare Trustees' Report, Bureau of Labor Statistics, Congressional Budget Office

The Medicare physician payment system lacks an adequate annual physician payment update, unlike those that apply to other Medicare provider payments. A continuing statutory freeze in annual Medicare physician payments is scheduled to last until 2026, when updates resume at a rate of 0.25% per year indefinitely, well below current rates of inflation.

Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. Several Medicare Trustees reports¹ have underscored that they “expect access to Medicare participating physicians to become a significant issue in the long term” unless Congress takes steps to bolster the system. The current Medicare physician payment system—with its lack of an inflationary update—is particularly destabilizing. **We therefore urge the passage of the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474),²** which provides a permanent annual update equal to the increase in the Medical Economic Index. Such an update would provide much needed financial stability for physicians and strengthen Medicare patients' access to care.

Physician payments are further eroded by the budget neutrality requirement within the Medicare Physician Fee Schedule. Budget neutrality requires spending on Medicare to have no budgetary impact—which means increases in payment for a subset of physician services in a given year require across-the-board decreases in payment for all physicians. This does not take into consideration the varying costs associated with performing these services. CMS actuaries have on occasion overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule. When these miscalculations are not adjusted in a timely way, it results in permanent removal of

¹ <https://home.treasury.gov/news/press-releases/jy1381>.

² <https://www.congress.gov/bills/118th-congress/house-bill/2474/text?s=1&r=1&q=%7B%22search%22%3A%22hr+2474%22%7D>.

billions of dollars from the payment pool. Increasing the budget neutrality threshold and allowing for corrections is one critically necessary step towards getting physicians out of the cycle of annual pay cuts. **As such, the AAO—HNS supports the *Provider Reimbursement Stability Act* (H.R. 6371),³** which would increase the budget neutrality threshold, allow for corrections of overestimates and underestimates of budget neutrality adjustments, and require timely updates to practice expense RVUs.

In summary, we urge action to improve the physician payment system by providing an inflationary payment update and revisiting budget-neutrality requirements.

Improving Alternative Payment Models (APMs) and Merit-based Incentive Payment System (MIPS)

Our specialty is actively involved in the transition of care, when safe and effective, from the inpatient setting to the hospital outpatient and Ambulatory Surgery Centers (ASC) settings and ultimately, the office setting, to increase flexibility and access to care while saving the overall healthcare system significant expense. Our specialty is engaged in defining quality for diagnosis and treatment of otolaryngologic disease using Clinical Practice Guidelines⁴ and a Clinical Data Registry⁵ that also works to improve outcomes, eliminate unnecessary care, and decrease costs.

Otolaryngologist—head and neck surgeons around the country are participating in various types of value-based care networks, including specialty-run clinically integrated networks and other shared savings models.

MACRA's Merit-based Incentive Payment System (MIPS) program was felt to have great promise when introduced, but the program has failed in most ways to deliver either savings or improved care. The majority of quality measures used in MIPS do not follow standard practice patterns of specialist physicians and have not shown any tracking toward improved patient outcomes, the final measuring stick. The only consistent quality of the MIPS program is that it gets more difficult and expensive by the year for physicians, especially those in independent practice, to comply with the cadre of rules promulgated annually.

The AAO—HNS recognizes that alternative payment models (APMs) may provide value-based care by providing incentive payments to deliver high-quality and cost-efficient care for a clinical condition, a care episode or a patient population. However, due to a lack of approved APMs that apply to specialty physicians, high initial costs of transitioning to an APM, and the looming end of the incentive payment, far fewer physicians participate in APMs than had been forecast. **Given the program's current shortcomings, the AAO—HNS supports the continuation of an extension of the 5% APM bonus payment to help physicians make the transition towards these evolving payment models.**

We offer the following recommendations for the Committee's consideration:

- A true value-based, quality program under Medicare should relate to the day-to-day practice of medicine and measure outcomes that are important to both physicians and their patients by measuring outcomes they are trying to achieve, not administrative markers. **To increase participation in MACRA or a successor program, one must also consider economic principles. Physicians must be compensated appropriately, and the administrative costs and complexity must not dissuade participation.** In terms of appropriate compensation, physicians must be treated equally to other Medicare providers and, at a minimum, receive annual payment updates based on an inflation proxy such as the Consumer Price Index (CPI).
- **In developing new measures of value-based care, CMS should work with each medical specialty society to develop best-care paradigms for the most common diseases/problems seen by each specialty.** These paradigms will serve as the underlying foundation for value-based care and allow for well-defined cost and quality alignment modeling. Performance feedback based on these best care paradigms will enable physicians to compare themselves to their peer group and help facilitate care improvement solutions. **In addition, value-based care measures should not be limited to claims data**

³ <https://www.congress.gov/bills/118/house-bills/6371/text?s=2&r=1&q=%7B%22search%22%3A%22hr+6371%22%7D>.

⁴ <https://www.entnet.org/quality-practice/quality-products/clinical-practice-guidelines/>.

⁵ <https://www.entnet.org/quality-practice/reg-ent-clinical-data-registry/>.

but should incorporate patient-reported outcomes. The data is there, and it should be incorporated.

- **It is important to maintain Qualified Clinical Data Registries (QCDRs) as an anchor to the current MIPS and any forthcoming Medicare quality improvement program.** These registries, such as the AAO—HNS' Reg-ent registry,⁶ can adequately recognize and incentivize high-quality care as well as identify areas for clinical improvement and cost savings.
- When having discussions around more equitable, value-based systems, **it is essential to allow flexibility through pilot studies to gather data on the value of each of these pilots before committing to one particular solution.** As we have learned through MACRA, there may not be one system that equitably fits all.
- A reliable cost-reduction strategy available to CMS is to transition care from high to low-cost facilities when clinically appropriate. As mentioned, our specialty can shift specific care away from hospital outpatient departments and into lower-cost Ambulatory Surgical Centers (or other non-facility settings). **To enable care in lower-cost facilities, Congress can urge CMS to provide appropriate reimbursement on both the physician work and practice expense portion for these services.** While this initially increases rates to the provider, it creates much greater savings to Medicare by avoiding the higher hospital outpatient fees. Accomplishing this will require Medicare Part B to have a similar funding mechanism as Medicare Part A that allows CMS flexibility to move away from the budget-neutral requirement that has created the current situation.

Supporting the healthcare team to transform chronic disease care

Physicians, including otolaryngologist—head and neck surgeons, and health systems across the country continue to face the growing challenge of preventing and managing chronic diseases. The Centers for Disease Control and Prevention estimates that 90% of all healthcare costs in the U.S. go toward treating chronic disease and mental health—about \$3.7 trillion a year. This highlights the need to support and create innovative approaches, such as team-based care, to ensure patients with chronic disease have access to both medical and surgical care—particularly in rural and underserved areas.

As the Committee considers changes to the current Medicare payment system, **flexibility in supporting the comprehensive physician-led healthcare team is essential to effectively managing the growing burden of chronic disease on the overall health system.**

Accounting for economic benefits of healthcare legislation

Allowing Congress the ability to look at the financial impact of preventive health legislation beyond the 10-year Congressional Budget Office (CBO) scoring window is another important tool that is critical for addressing chronic conditions. That is why the AAO—HNS has endorsed the *Dr. Michael C. Burgess Preventive Health Savings Act* (H.R. 766/S. 114), which would allow Congress to consider the long-term economic benefits of legislation that promotes wellness and reduces the incidence of chronic conditions. It is widely recognized that preventing a chronic condition will improve health outcomes, reduce costs to our healthcare system, and provide patients with a better quality of life. **It is time for the CBO to have an updated scoring methodology that accounts for these long-term economic benefits, and therefore, we urge Congress to pass the Dr. Michael C. Burgess Preventive Health Savings Act.**

Again, we thank the Senate Finance Committee for furthering the discussion to improve Medicare physician payment and increase patient access. The AAO—HNS stands ready to offer ourselves as a resource for further discussions. If you have any questions or require further information, please contact govtaffairs@entnet.org.

Sincerely,

James C. Denny III, M.D.
Executive Vice President and CEO

⁶<https://www.entnet.org/quality-practice/reg-ent-clinical-data-registry/>.

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U.S. Senate
 Committee on Finance
 219 Dirksen Senate Office Building
 Washington, DC 20510-6200

April 11, 2024

Dear Chairman Wyden, Ranking Member Crapo and Members of the Committee,

On behalf of the American Association of Clinical Urologists (AACU) we wanted to send in our comments on the April 11, 2024 hearing titled “Bolstering Chronic Care through Medicare Physician Payment.”

Founded in 1968 by urologists concerned by the government’s increasing role in the practice of medicine, the AACU is a professional organization representing the interests of more than 3,700+ member urologists, and urologic societies engaged as advocacy affiliates across the United States. We are dedicated to developing and advancing health policy education as it affects urologic practice in order to preserve and promote the professional autonomy of our members and support the highest quality of care for Patients.

On behalf of our urology members, we remain cautiously optimistic that Congress will finally come to the correct policy decision in order to protect physicians by awarding an adequate and sustainable reimbursement metric for our members. This is especially true for urologists whose patients are dealing with chronic conditions. If these conditions aren’t managed appropriately, these conditions will undoubtedly be another cause of significantly contributing to the alarmingly increasing higher drug spend in our country.

Urologists care deeply about patient access and adherence and improved outcomes but have found the last several years difficult to achieve this due to Medicare’s constantly shrinking reimbursement metrics. Physicians have been pleading for Congress to solve this issue for years since this problem is now being compounded with others that threaten our healthcare system. From physician shortages due to retirements and low reimbursements, to increased wages and operational expenses as a direct result of the physician shortages, our industry is in trouble. All the while we are expected to continue business and usual when our patients need us the most. Something has to give.

Notwithstanding, we have been grateful for Congress’ effort to pass a skinny package of health extenders for fiscal 2024 in early March that included a 1.68% partial fix for the 3.37% cut to Medicare physician payments. We are also hopeful that conversations between the Medicare payment reform working group, MedPAC and this Committee will hear our concerns and put a permanent solution in place such as directing the Centers for Medicare and Medicaid Services (CMS) to include an inflationary index to the conversion factor so that the income of providers is not eroded over time due to the effects of inflation.

We look forward to serving as a resource to you and this Committee.

Please reach out to Ron Lanton, AACU Director of Government Affairs at rlanton@aacuweb.org with any questions or concerns.

Sincerely,

Harbhajan S. Ajrawat, M.D., FACS
 President

Ian M Thompson III, M.D.
 Health Policy Chair

AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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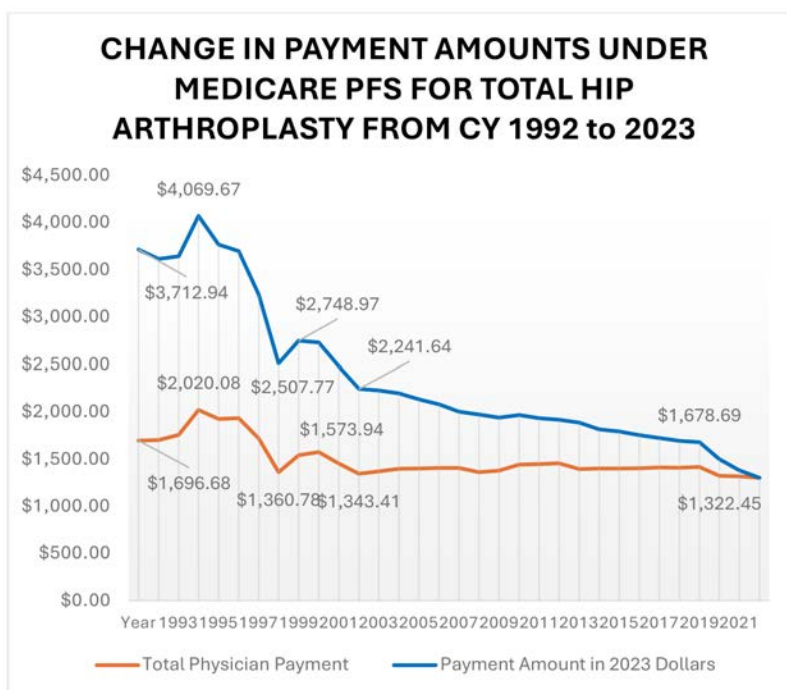
Chairman Wyden and Ranking Member Crapo, thank you for holding this hearing on critical patient care improvements and Medicare Physician Fee Schedule (“MPFS”) reforms that are necessary to provide stability and appropriate levels of

support for the care that hip and knee surgeons provide to beneficiaries across the country.

AAHKS is the foremost national specialty organization of more than 4,900 physicians with expertise in total joint arthroplasty (“TJA”) procedures. Many of our Members conduct research in this area and are experts on the evidence-based medicine issues associated with the risks and benefits of treatments for patients suffering from lower extremity joint conditions. AAHKS is guided by four principles:

- Patient access, especially for high-risk patients, and physician incentives must remain a focus;
- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- Payment reform is most effective when physician-led; and
- The burden of excessive physician reporting on metrics detracts from care.

Continued Medicare cuts to physician reimbursement for total hip and knee arthroplasty, which have drastically outpaced overall cuts to the Physician Fee Schedule over the past 30 years, is one of the primary factors driving health care consolidation and the growing inability of physicians to maintain an independent practice. AAHKS appreciates the hearing statements from Committee Members and witnesses regarding the unsustainable MPFS annual updates, and the harm that the MPFS budget neutrality function inflicts when reimbursement for some services are increased causing completely unrelated services to be cut.



- The cuts to total hip and knee arthroplasty are not grounded in the value to our patients, advancements in patient care, or the effort that our members invest in improving outcomes and reducing overall spend for the procedure. The cuts have also come from multiple aspects of the Medicare program, each of which has major policy implications for this Committee’s priorities for the Medicare program. We urge the Committee to consider the cumulative impact of the following cuts on our Members and the Medicare beneficiaries they serve: Devaluing total hip and knee arthroplasty’s primary surgical code (*i.e.*, unjustified reduction in relative value units (RVUs) as advocated by a private insurer).

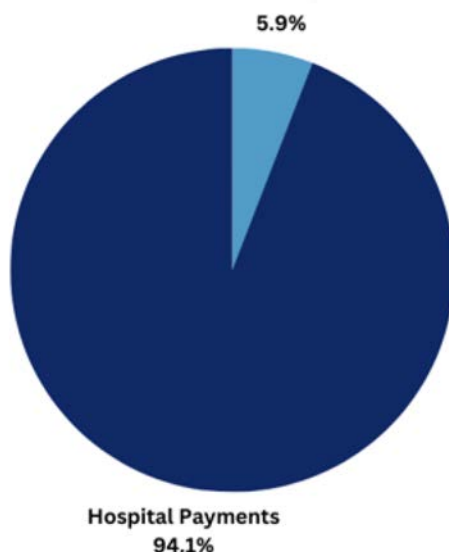
- Not recognizing surgeons' increasing role in value-based driven work managing patient health through primary care-like pre-surgical optimization and coordination services.
- Unilaterally regrouping the procedures used to value different TJA procedures (*i.e.*, shifting Ambulatory Payment Classification ("APC") code groupings without public notice or the opportunity to comment or any input from physicians on clinical matters).
- Reductions in the Alternative Payment Model ("APM") participation payment.
- Cuts caused by unrelated MPFS services being increased (budget neutrality function of MPFS).
- The lack of an inflationary update to the MPFS despite escalating costs.

All of these cuts are exacerbated by the growth and capriciousness of prior authorization programs that ignore patient clinical needs, and rising complexity and administrative burdens from all payers.

There is no doubt that TJA reimbursement has been a disproportionate target of physician cuts because it is Medicare's largest procedural code. Americans are living longer, as your Committee well knows, are increasingly burdened with comorbidities that accelerate the end-stage osteoarthritis and necessitates a total hip and knee replacements. As such, there is urgent demand for our Members' surgical interventions but cuts to TJA physician reimbursement *undermine* the goal of improving care and reducing costs. Advancements in patient care, pioneered by many of our Members, have drastically reduced hospital patient days, improved recovery times, reduced use of opioids and saved the Medicare program billions. We urge the Committee support our physicians in their continued efforts to bring value to the Medicare beneficiary and the Medicare Trust Funds.

Beyond undermining physician work that benefits Medicare beneficiaries and reduces total Medicare expenditures, there is a basic math problem in the strategy of cutting surgeon reimbursement year-over-year to achieve savings: Surgeons represent less than 6% of the overall cost of hip and knee replacement, but their services are essential to controlling costs in the other 94%.

Where are the costs in TJA?



There are deeply concerning policy implications for patient care associated with chronic reductions in physician reimbursement in response to growing demand, improved outcomes, increased physician labor, rising practice costs and complex ad-

ministrative burdens. If the goal is purely savings, it's not in the best interest of the program or Medicare beneficiaries to undermine the lowest-cost/highest-value clinical partner the Centers for Medicare and Medicaid Services (CMS) has to improve care and control costs.

HIP & KNEE SURGEONS HAVE THE HIGHEST LEVEL OF PARTICIPATION IN APMs

Hip and knee surgeons have been at the forefront of the transition to value-based models of care. Our members have worked with CMS to develop existing alternative payment models ("APMs"), improve risk-adjustment models to ensure all patients have equitable access to care, and develop new global payment models for osteoarthritis which will result in even more hip and knee surgeons joining innovative models of care. They were early voluntary adopters of the Bundled Payments for Care Improvement (BPCI) model, where physician-led bundles have improved care and reduced costs. Their procedures were also the first to be subjected to a mandatory Centers for Medicare and Medicaid Innovation (CMMI) APM: the Comprehensive Care for Joint Replacement Model (CJR). There is no other subspecialty with a greater level of participation in APMs, as our members approach 50% participation.

Members of AAHKS have worked for several years on developing a longitudinal osteoarthritis disease state model that leverages our surgeons' unrecognized work as the primary care provider for Medicare beneficiaries with osteoarthritis. This model represents a paradigm shift that aligns risk-sharing with effective management of the underlying condition that can lead to TJA and removing barriers to care when TJA is necessary; improving patient outcomes, safeguarding the Medicare trust fund, and reducing administrative burdens.

AAHKS agrees with the comments by hearing witnesses regarding the need for enhanced clinical stakeholder input in APM development. While AAHKS has been grateful for some of the changes that the CMMI has made as a result of AAHKS engagement, improving clinical stakeholders' ability to effectively improve APM design is critical for their success. We share witness concerns that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has recommended 14 models for implementation, and none of them has been implemented; including the longitudinal osteoarthritis model AAHKS members have proposed.

APM PATIENT CARE IMPROVEMENTS & SAVINGS HAVE BEEN USED TO JUSTIFY ADDITIONAL PHYSICIAN CUTS

While our surgeons are proud to be APM pioneers, they have also been the first to hit the policy speed-bumps on the onramp to value-based care. One of the most problematic cuts to TJA reimbursement stemmed directly from AAHKS-members success in APMs. This was the result of the disconnect between fee-for-service Medicare rate-setting policies and the work our physicians do in APMs.

One of the main drivers of savings for TJA within the CJR and BPCI has been our surgeon's work with patients to optimize their health prior to surgery. Similar to primary care and care-coordination services, this "pre-surgical optimization" requires our surgeons to work with patients in the weeks and months prior to surgery to address health conditions that could complicate their surgical outcomes (*e.g.*, reduce their body mass index (BMI), treat hypertension, manage diabetes management, etc). The results of this work are that patients are healthier, have better surgical outcomes, and shorter recovery times. This not only lays the groundwork for improved patient experience, but results in significant Medicare savings by reducing hospital stays.

This is an example of the <6% of overall TJA reimbursement to surgeons being leveraged to reduce costs for the other 94% of the total procedure reimbursement. This is only possible through the tremendous amount of work our surgeons do outside of the operating room. However, in 2018 an American Medical Association (AMA) RVS Update Committee (RUC) review of THA and TKA was initiated anonymously by a national for-profit insurance company¹ used the physician reimbursement review process to allege that Medicare THA/TKA reimbursement, along with

¹Private insurance companies stand to gain from a proposed reduction by the AMA RUC by reducing their own payments to surgeons under commercial insurance arrangements that are pegged to a percentage of the national Medicare rate.

many other procedures are overvalued. For hip and knee replacement, the insurance company based this allegation *mainly on one study of only two facilities*.

Due to the limitations of the current RUC process, only work done 24 hours prior to a surgical procedure and 90 days afterwards was considered. Subsequently, it did not recognize all the pre-service work incentivized over the weeks/months in APMs, but did recognize the resulting shorter hospitalizations and fewer post-operative doctor visits. This was despite being presented with a study that accounted for the time commitment needed for delivery of value-based patient care and an independent *national* survey of AAHKS members, it was found that more than 98% of respondents are providing preoptimization services. The RUC ultimately recommended a cut in TKA and THA reimbursement, despite acknowledging that the pre-optimization work was occurring. CMS finalized the recommended cut in 2021.

These cuts fundamentally undermine the investments AAHKS members have made to improve patient care and take on substantial risk in APMs to reduce overall Medicare spending. The real work that thousands of our surgeons do, backed up by studies and a national survey, was discounted by an anonymously submitted two-site survey that was never intended to capture the value of the services our surgeons provide to their patients and the Medicare program. It sends a chilling message to *all* physicians that high levels of participation and success in APMs will result in punitive compensation cuts for their services.

AAHKS was encouraged to hear Committee Members support for coordinated care. During the hearing, a Member of the Committee asked the panel how to create payments to incentivize physicians to provide the “right care”. We strongly urge the Committee to address the disconnect between fee-for-service rate-setting process and the valuable work that occurs within APMs and reverse the cuts that hip and knee surgeons received for providing the right care.

EXTENSION OF APM PARTICIPATION PAYMENT

AAHKS strongly supports the extension of the full 5% APM participation payment. We appreciate that Congress extended the participation at 1.88% on March 8th, and that the payment could have lapsed entirely without allocating limited federal funds to this priority. However, AAHKS is concerned that the reduced reauthorized payment is not sufficient to speed physician adoption of value-based care and support continued participation in APMs.

AAHKS supports the Committee Member and witness statements highlighting the importance of the payment for APM uptake, and we urge the Committee to consider the importance of ongoing support while CMS is still developing, testing and changing APMs. While many of our members already participate in APMs, they are frequently updated with new target benchmarks, risk adjustment methodology and other program elements. Supporting current APM participants through these changes is also an important function of the participation payment. AAHKS is concerned by some policy proposals that have introduced the concept of phasing-out of the APM participation fee based on how long a participant has been in an APM. We urge the Committee to recognize the changing nature of CMMI APMs and reject phase-out proposals, especially amid increasing practice expenses and reimbursement pressures outlined in this statement.

PRIOR AUTHORIZATION: A BARRIER FOR PATIENT CARE, A BURDEN FOR PHYSICIANS

AAHKS appreciates the Committee’s attention to prior authorization reform, and the hearing comments of Members and witnesses regarding ongoing challenges to patient access to care and physician administrative burdens.

Delays for our patients translate into more days wrestling with the pain of osteoarthritis; more days away from their jobs and basic activities they enjoy. Our surgeons have dedicated their careers to restoring our patients to a pain free, productive and mobile life. It is a daily occurrence to have their medically necessary care delayed by prior authorization decisions made by reviewers without expertise in TJA that deeply conflict with the health care needs of the Medicare beneficiary.

Within a declining reimbursement environment, hip and knee surgeons have been diverting more time and resources ensuring their patients are covered for their medically necessary TJA. It is commonplace, even in small independent practices, to have full-time staff handling prior authorization documentation. There is no separate revenue stream to support those staff; it all comes out of the dwindling 6% of reimbursement surgeons receive for the total TJA episode of care.

We support the finalized regulations that modernize prior authorization programs within Medicare Advantage.² We look forward to sharing with the Committee additional suggested reforms to ensure that patient access to care is not delayed.

AAHKS is interested in providing stakeholder feedback on the draft “prior authorization for prior authorization” legislation mentioned during the hearing. We support the need for stricter parameters, and strong justification for the implementation of any prior authorization program or new requirements within existing prior authorization programs.

APPROPRIATE SETTING FOR APPROPRIATE CARE

It is essential that the most appropriate setting of care for a major surgery is a decision made by the physician and their informed patient. Prior authorization programs can interfere with *when* a patient can receive care, but other recent Medicare policy changes have made substantial changes to *where* a patient can receive TJA.

Until 2018, all lower-joint TJAs were performed in the inpatient setting, and CMS maintained the procedures on the “inpatient-only list” (“IPO”). CMS began removing the procedures from the IPO list in 2018, when they made total knee replacement surgery available in the outpatient setting for the first time. In 2019 they allowed for the procedure in Ambulatory Surgery Centers (“ASCs”) in 2019, and total hip replacement surgery followed in 2020.

AAHKS supports the ability for the physician to choose the most clinically appropriate setting for their patients’ treatment. However, procedures coming off the Medicare inpatient-only list do not have established clinical criteria within Medicare’s “Two-Midnight Rule” to ensure the availability of inpatient care for medically complex patients. That creates ambiguity unique to procedures coming off the IPO list that has caused many hospitals to push patients into the outpatient setting, regardless of clinical considerations, for fear of audits and penalties.

AAHKS recommends that any legislative action on the Medicare IPO list include a requirement for clear Two-Midnight Rule guidance for procedures coming off the IPO list to ensure that patients are treated in the most clinically appropriate setting of care.

CHOICE IS THE KEY TO ADDRESSING CONSOLIDATION

Continued cuts to Medicare reimbursement makes it more difficult for surgeons to sustain independent practices or have a realistic range of options for practice models. This leads to mergers and consolidation. Consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care—particularly in rural and underserved areas. Reduced reimbursement for Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) can also lead to surgeons shifting their focus to other procedures and conditions for which they have trained, despite the accelerating need for joint replacement in the Medicare age eligible population.

AAHKS supports surgeons that work across all employment arrangements, from small independent practices to academic medical centers. Physicians should have a choice of the setting in which they work; however, their ability to choose is diminishing as a result of the dwindling 6% of the total reimbursement for TJA they receive to keep their practices afloat. The financial strain imposed on small practices drives consolidation and, in turn, increases the cost of care for the Medicare program and beyond.

In light of President Biden’s Executive Order on Promoting Competition in the American Economy, CMS should evaluate whether its proposed reductions in Medicare physician rates promote competition in health care or facilitate consolidation. AAHKS is optimistic for the future passage of H.R. 3284, the *Providers and Payers COMPETE Act of 2023*, which recently was reported out of the House Committee on Energy and Commerce by a vote of 49–0. HR 3284 would require the Secretary of the Department of Health and Human Services (HHS) to assess and report to Congress on the impact of any Medicare reimbursement or regulatory changes on consolidation of healthcare providers and payers. Such reporting is an important step to better inform Congress and CMS on how not to exacerbate health industry consolidation through Medicare payment rates reductions.

² 89 FR 8758.

Conclusion

AAHKS appreciates the Committee's attention to the urgent need to address beneficiaries' chronic care needs through Medicare physician payment reform and looks forward to partnering with the Committee in its work. As Americans live longer and increasingly struggle with comorbidities that can exacerbate osteoarthritis, our surgeons provide a lifeline to return them to a pain-free, productive, and healthier life. With the right supports, our Members are ready and able to meet the growing demand for TJA to continue bringing value to beneficiaries and their families.

AAHKS appreciates the Committee's consideration of the perspectives shared in this Statement for the Record. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

AMERICAN ASSOCIATION OF NURSE PRACTITIONERS
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The American Association of Nurse Practitioners (AANP), representing the 385,000 Nurse Practitioners (NPs) in the United States, appreciates the opportunity to provide a statement for the record for the Senate Committee on Finance hearing entitled "Bolstering Chronic Care through Medicare Physician Payment." AANP is committed to empowering all NPs to advance high-quality, equitable care, while addressing health care disparities through practice, education, advocacy, research, and leadership (PEARL).¹ We appreciate the Committee's attention to Medicare reimbursement policies and their impact on patient access to care. We thank Chairman Wyden and Ranking Member Crapo for holding this hearing. Members and expert witnesses identified the need to address the structural inequities within the Medicare reimbursement model which inhibit beneficiary access to coordinated, whole-person, patient-centered care. We look forward to working with the Committee on a Medicare reimbursement model which equitably reimburses NPs for the care they provide to patients.

This issue is of particular importance to our members, as NPs provide a substantial portion of the high-quality,² cost-effective³ care that our communities require. As of 2021, there were over 193,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.⁴ Approximately 42% of Medicare patients receive billable services from a nurse practitioner,⁵ and approximately 80% of NPs are seeing Medicare and Medicaid patients.⁶

NPs also provide a significant portion of health care in rural areas and areas of lower socioeconomic and health status. As such, they understand the barriers to care that face vulnerable populations on a daily basis.^{7, 8, 9} They are also "significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians."¹⁰

¹ <https://www.aanp.org/advocacy/advocacy-resource/position-statements/commitment-to-addressing-health-care-disparities-during-covid-19>, <https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners-aanp/strategic-focus>.

² <https://www.aanp.org/images/documents/publications/qualityofpractice.pdf>.

³ <https://www.aanp.org/images/documents/publications/costeffectiveness.pdf>.

⁴ <https://data.cms.gov/> MDCR Providers 6 Calendar Years 2017–2021.

⁵ *Ibid.*

⁶ NP Fact Sheet (aanp.org).

⁷ Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *Journal of General Internal Medicine*, 4–6. <https://doi.org/10.1007/s11606-017-4287-4>.

⁸ Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010–2016. *Journal of the American Medical Association*, 321(1), 102–105.

⁹ Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. *Medical Care Research and Review*, Epub ahead. <https://doi.org/10.1177/1077558718793070>.

¹⁰ <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/>.

As has been highlighted by MedPAC and data from the Centers for Medicare and Medicaid Services, NPs provide a growing amount of care to Medicare beneficiaries. As noted above, in the June 2022 report to the Congress, the Medicare Provider Advisory Commission (MedPAC) found that NPs and PAs comprise approximately one-third of the primary care workforce, and up to half in rural areas.¹¹ Along with primary care, MedPAC has also published data on the importance of NPs providing mental and behavioral health care.¹² NPs are also the second largest provider group in the National Health Services Corps¹³ and the number of NPs practicing in community health centers has grown significantly over the past decade.¹⁴

We strongly support the opening statement by Chairman Wyden which notes the importance of empowering health care providers who are managing and coordinating patient care. We further agree that Medicare's "out-of-whack payment rules"¹⁵ do not reflect the modern delivery of health care, and that all providers "need to be valued and compensated more fully by Medicare."¹⁶ As Ranking Member Crapo stated in his testimony, "Medicare's coverage and payment policies play a dominant role in setting benchmarks and baseline rules of the road not just for the program itself, but also for countless other payers"¹⁷ which impacts patients across the spectrum of care. Therefore, we concur that "structural fee schedule reforms should shift away from the status quo, which forces clinicians to vie for ever-dwindling resources and move toward models that promote and reward team-based, patient-centered approaches."¹⁸

It is critical that Medicare's payment policies are updated to reflect the modern delivery of health care. When the Medicare fee schedule was initially introduced, nurse practitioners were authorized to bill Medicare on a limited basis. However, there has been a significant evolution in providers who bill the Medicare program, and the fee schedule is no longer limited to physicians. It sets the rates and policies for a broad spectrum of providers who bill Medicare, including NPs. As Congress has taken action to expand which clinicians are authorized to bill the Medicare program, many Medicare statutes and payment policies do not reflect these changes.

Included below are our suggested proactive policy solutions which would work towards the important goals identified by the Committee members, including increasing access to care, and equitably reimbursing providers. These policies include addressing the 15 percent payment reduction NPs receive in the Medicare program, including NPs within the Health Professional Shortage Area (HPSA) Medicare bonus, including NPs within the Medicare fee schedule valuation process, and removing longstanding barriers within the Medicare program. We greatly appreciate your consideration of this statement and look forward to working with the Committee on these issues.

Equitable Reimbursement for Nurse Practitioners

As NPs continue to provide increasing amounts of care for Medicare patients, it is important to understand the significant evolution of the role of NPs in Medicare. In 1977, Congress first formally recognized care delivered by nurse practitioners in the Medicare program in rural health clinics.¹⁹ In 1989, Congress authorized direct reimbursement under the Medicare program for services rendered by nurse practitioners in rural areas, and indirect reimbursement for NPs rendering services in skilled nursing facilities.²⁰ Since 1997, Congress has authorized reimbursement under the Medicare program to NPs regardless of setting or geographic area, for any services that would be covered when provided by a physician, in accordance with State law, at 85% of the fee schedule rates.²¹

¹¹ https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2).

¹² https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

¹³ <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf>.

¹⁴ <https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf>.

¹⁵ https://www.finance.senate.gov/imo/media/doc/0411_wyden_statement.pdf (senate.gov).

¹⁶ *Ibid.*

¹⁷ https://www.finance.senate.gov/imo/media/doc/0411_crapo_statement.pdf (senate.gov).

¹⁸ *Ibid.*

¹⁹ <https://www.govinfo.gov/content/pkg/STATUTE-91/pdf/STATUTE-91-Pg1485.pdf> (govinfo.gov).

²⁰ <https://www.govinfo.gov/app/details/STATUTE-103/STATUTE-103-Pg2106> (govinfo.gov).

²¹ 63 FR 30862, <https://www.govinfo.gov/content/pkg/FR-1998-06-05/pdf/98-14650.pdf>.

Since this policy was implemented in 1997, despite the increasing importance of NPs in Medicare, the reimbursement structure has not changed in over 26 years. NPs are still reimbursed at 85% of the fee schedule for the services they provide. This means that if an NP provides a patient with the exact same service, with the exact same components and time requirements as their physician colleagues, they are paid 15% less. This 15% differential is significant and is in addition to other factors which impact reimbursement rates, including statutory reductions and corresponding adjustments to the conversion factor.²² It is important to note that inflation and other financial pressures identified by the Committee members are exacerbated for NPs due to this decreased reimbursement rate. This inequitable reimbursement structure is an anachronism and does not reflect the modern health care system.

Therefore, we respectfully request that the Committee address the inequitable reimbursement structure for NPs within the Medicare program, and ensure any legislation includes equitable reimbursement for nurse practitioners. This is directly aligned with NAM *Future of Nursing* report which stated, “Payment reform can help improve population health, address social needs and [social determinants of health], reduce health disparities, supporting the provision of effective, efficient, equitable, and accessible care for all across the care continuum instead of incentivizing the volume of care or low value procedures and practices.”²³

Medicare Payment in Rural and Underserved Communities

Nurse practitioners are a critical, and growing, part of the health care workforce. While reimbursement equity is an important principal regardless of geographic location, we recognize the unique challenge of rural and underserved communities in addressing clinician shortages. As noted above, in the June 2022 report to the Congress, MedPAC found that NPs and PAs comprise approximately one-third of the primary care workforce, and up to half in rural areas.²⁴ When rural communities experience hospital closures, it is often NPs who are filling the gaps and providing critical care to these communities. According to the Government Accountability Office (GAO), an exception to the pattern of clinicians leaving rural areas after rural hospital closures were APRNs, finding that “[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent).”²⁵

However, despite the importance of NPs to the health care workforce in rural and underserved communities, NPs are not eligible for the 10% Medicare bonus available to their physician colleagues in health professional shortage areas (HPSAs).²⁶ For NPs in HPSAs, this means there can be up to a 25% difference in reimbursement rates between NPs and their physician colleagues.²⁷ This differential is substantial, and impacts both primary care and mental health HPSAs. According to the Health Resources and Services Administration (HRSA), there are currently 101 million patients living in 8,504 Primary Care HPSAs which require 17,463 practitioners. There are 166 million patients living in 6,767 Behavioral Health HPSAs which require 8,358 practitioners.²⁸

As the Committee considers policy options to better support rural and underserved providers, ensuring NPs practicing in rural and underserved communities have equitable access to the HPSA Medicare Bonus Program is critical. **Therefore, we respectfully request the Committee update the Medicare HPSA incentive bonus program to include NPs.** This is aligned with the FY 2025 Department of Health and Human Services (HHS) Budget in Brief²⁹ which included a legislative proposal to broaden the HPSA incentive program to include NPs. In the request, HHS notes that “This proposal responds to the evolving delivery of healthcare in the United States. Academic research found that the share of medical visits deliv-

²² CY 2024 Medicare Physician Fee Schedule Final Rule, <https://www.cms.gov/newsroom/press-releases/cms-finalizes-physician-payment-rule-advances-health-equity>.

²³ The Future of Nursing 2020–2030—National Academy of Medicine, <https://nam.edu/publications/the-future-of-nursing-2020-2030/> (nam.edu).

²⁴ https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2).

²⁵ <https://www.gao.gov/assets/gao-21-93.pdf>.

²⁶ Physician Bonuses, CMS, <https://www.cms.gov/medicare/payment/fee-for-service-providers/physician-bonuses-health-professional-shortage-areas-hpsas>.

²⁷ Health Professional Shortage Area Physician Bonus Program, <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/HPSAfcstshTextOnly.pdf> (hhs.gov).

²⁸ Shortage Areas, <https://data.hrsa.gov/topics/health-workforce/shortage-areas> (hrsa.gov).

²⁹ *Ibid.*

ered by nurse practitioners or physician assistants increased from 14 percent to 26 percent among Medicare beneficiaries between 2013 and 2019. Research also found that nurse practitioners make up a larger share of the primary care workforce in lower income and rural areas.”

The confluence of the COVID-19 PHE, opioid epidemic and behavioral health workforce shortages have led to an ongoing behavioral health crisis in the United States. According to HRSA, more than one-third of Americans live within mental health professional shortage areas.³⁰ Data demonstrates that nurse practitioners have been critical in filling access gaps and providing mental and behavioral health care to Medicare beneficiaries. A recent study published in *Health Affairs* found that from 2011–2019 the number of psychiatric-mental health NPs (PMHNPs) treating Medicare beneficiaries grew by 162%, compared to a 6% drop in psychiatrists during that same period.³¹ The study also found that the proportion of all mental health prescriber visits provided by PMHNPs to Medicare beneficiaries increased from 12.5% to 29.8% during that same period, exceeding 50% in rural, full practice authority regions.³²

In addition, MedPAC found “large shifts in the behavioral health workforce over time: Between 2016 and 2021, substantial growth in behavioral health services provided by nurse practitioners occurred, while volume by psychiatrists declined.”³³ The report also states that “we found shifts over time in the specialty of the clinicians who provide Part B behavioral health services. Most notably, between 2016 and 2021, the volume of these services provided by psychiatrists declined (5 percent average annual decrease) and rose for nurse practitioners (12 percent average annual increase).”³⁴ **Accordingly, we also support section 101 of the *Better Mental Health Care, Lower-Cost Drugs, and Extenders Act* which would expand the HPSA bonuses to 15% for mental health and substance use disorder services provided in mental health HPSAs by a broader group of clinicians, including NPs.**

Increase Access by Removing Federal Medicare Barriers

In the hearing, Senator Grassley highlighted the need to remove federal barriers that prevent clinicians from practicing to the full extent of their state scope of practice, to strengthen access to care and improve outcomes. We strongly agree with updating outdated federal statutes which do not reflect the modern provision of health care and prevent NPs from fully meeting the health care needs of their communities. Reports issued by the National Academies of Medicine,³⁵ American Enterprise Institute,³⁶ the Brookings Institution,³⁷ the Federal Trade Commission,³⁸ the Bipartisan Policy Center³⁹ and the U.S. Department of Health and Human Services under multiple administrations^{40, 41, 42} have all highlighted the positive impact of removing barriers confronted by NPs and their patients. The World Health Organization’s *State of the World’s Nursing 2020* report also recommends modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training, and noted the positive impact this would have on addressing health care disparities and improving health care access within vulnerable communities.⁴³ As noted by MedPAC data, the number of encounters per FFS beneficiary

³⁰ 88 FR 52366.

³¹ Trends in Mental Health Care Delivery By Psychiatrists and Nurse Practitioners in Medicare, 2011–19, *Health Affairs*, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00289?journalCode=hlthaff>.

³² *Ibid.*

³³ https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

³⁴ *Ibid.*

³⁵ The Future of Nursing 2020–2030—National Academy of Medicine, <https://nam.edu/publications/the-future-of-nursing-2020-2030/> (nam.edu).

³⁶ <https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf>.

³⁷ https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.

³⁸ <https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy>.

³⁹ Strengthening the Health Professional Workforce, Bipartisan Policy Center, <https://bipartisanpolicy.org/blog/strengthening-health-professional-workforce/>.

⁴⁰ <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>.

⁴¹ <https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners>.

⁴² <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>.

⁴³ <https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf>.

with APRNs and PAs increased by 10.4 percent from 2021–2022.⁴⁴ This increase underscores the urgent need for Congressional action to remove these barriers to care.

As the Committee works on legislation to enhance access to care, we strongly encourage inclusion of the following bipartisan legislation; the *Promoting Access to Diabetic Shoes Act* (S. 260), the *Improving Care and Access to Nurses Act* (S. 2418), and the *Increasing Access to Quality Cardiac Rehabilitation Care Act of 2023* (S. 3481). These bipartisan bills will reduce the administrative burden for NPs and increase needed access to care for patients. This is especially true in rural and underserved communities, where requiring unnecessary visits, referrals or certifications presents immense challenges for patients.

Promoting Access to Diabetic Shoes Act (S. 260)

S. 260 would authorize NPs to satisfy the documentation requirement for coverage of therapeutic shoes for individuals with diabetes. NPs provide the full range of care to patients with diabetes, but federal law requires that an NP must send a patient who needs therapeutic shoes to a physician to certify that need. Additionally, according to current statute, the certifying physician must take over the treatment of the patient's diabetic condition going forward. These barriers often lead to delays in accessing needed items and undermine care continuity. The estimated total annual cost of an individual patient with diabetes is \$17,000.⁴⁵ However, if left untreated, patients with diabetes may face serious complications including foot ulcers or amputations, driving up the estimated annual individual costs to \$52,000.⁴⁶ By removing this outdated and unnecessary barrier, NPs would be authorized to certify the need for therapeutic shoes for patients with diabetes, and ensure they get the care they need in a timely fashion.

Passage of this legislation will also reduce Medicare spending by eliminating duplicative services. Removing the unnecessary additional certifying visit requirements could save the Medicare program \$12.1 million annually.⁴⁷ Data also demonstrates that NPs manage the care for patients with diabetes in a cost-effective manner that results in health care savings. A recent study utilizing Veterans Affairs (VA) data from FY 2013 found significant savings, 6–7% lower costs, for highly complex diabetic patients who had an NP as their primary provider compared to those with a physician.⁴⁸ Other researchers found even greater savings, 12–13% lower costs when examining patients with diabetes with varying degrees of complexity served by the VA. For a single VA medical center, this equated to an annual savings of just over \$14 million, exemplifying the efficiency and effectiveness of NP delivered care in the VA.⁴⁹ Patients who choose nurse practitioners as their health care providers deserve equitable access to care from their chosen health care provider.

Improving Care and Access to Nurses (ICAN) Act (S. 2418)

S. 2418 would update the Medicare and Medicaid programs to ensure that NPs and other APRNs are authorized to provide care as effectively and efficiently as possible, consistent with state law. This includes updating Medicare and Medicaid to remove barriers to evidence-based preventive services such as authorizing NPs to order cardiac and pulmonary rehabilitation, refer patients for medical nutrition therapy, certify patients' needs for diabetic shoes, establish home infusion plans of care, and perform mandatory visits in skilled nursing facilities. This bill does not supersede any state laws, it simply modernizes these provisions within Medicare and Medicaid to make them consistent with state law to ensure that beneficiaries have access to these health care services, from their provider of choice, without undue burden. This legislation is supported by over 235 national, state, and local organizations⁵⁰ includ-

⁴⁴ [medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf).

⁴⁵ American Diabetes Association. (2018). Economic Costs of Diabetes in the U.S. in 2017. *Diabetes Care*, 41, 917–928. <http://care.diabetesjournals.org/content/diacare/early/2018/03/20/dci18-0007.full.pdf>.

⁴⁶ Agency for Healthcare Research and Quality (2011). Data points #3: Economic burden of diabetic foot ulcers and amputations. <https://effectivehealthcare.ahrq.gov/topics/diabetes-foot-ulcer-amputation-economics/research>.

⁴⁷ Analysis based on author calculations. Approximately 134,000 Medicare patient visits billed using an established patient level 3 E/M code (CPT 99213).

⁴⁸ Morgan, et al. (2019). Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients. *Health Affairs*, 38(6), 1028–1036. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00014>.

⁴⁹ Rajan, et. al (2021) "Health care costs associated with primary care physicians versus nurse practitioners and physician assistants." <https://pubmed.ncbi.nlm.nih.gov/34074952/>.

⁵⁰ <https://www.aanp.org/news-feed/more-than-235-organizations-show-their-support-for-the-ican-act>.

ing the National Rural Health Association, National Association of Rural Health Clinics, American Health Care Association, LeadingAge, Americans for Prosperity, and AARP.⁵¹ Patients who choose NPs as their health care providers should not face increased burdens and decreased access to medically necessary treatment that are covered by Medicare and Medicaid.

Increasing Access to Quality Cardiac Rehabilitation Care Act (S. 3481)

S. 3481 would authorize NPs to order cardiac and pulmonary rehabilitation for Medicare patients. In 2018, Congress passed legislation which authorized NPs, clinical nurse specialists (CNSs) and physician assistants (PAs) to supervise cardiac and pulmonary rehabilitation starting in 2024. However, these clinicians are still not authorized to order cardiac and pulmonary rehabilitation for Medicare patients.

Cardiac rehabilitation and pulmonary rehabilitation are programs designed to improve a patient's physical, psychological, and social functioning after a qualifying diagnosis or procedure, such as a heart attack or coronary artery bypass surgery or after a diagnosis of chronic obstructive pulmonary disease (COPD). Heart disease remains the leading cause of death in the United States with nearly 700,000 deaths per year.⁵² Not only does heart disease have a tremendous impact on the lives of patients and their families, but managing and treating heart disease and related risk factors is estimated to cost the United States over \$320 billion annually.⁵³ Chronic obstructive pulmonary disease (COPD) is the sixth leading cause of death in the United States, with nearly 150,000 deaths per year.⁵⁴ COPD is estimated to cost the United States nearly \$50 billion annually in related health care expenditures and indirect mortality and morbidity costs.⁵⁵

Yet, while studies show that these programs can reduce hospitalizations, decrease heart attack recurrence, increase adherence to preventive medication, improve overall health and reduce the need for costly care, less than 25 percent of qualifying patients receive cardiac rehabilitation and only three percent of Medicare patients with COPD receive pulmonary rehabilitation.^{56, 57, 58} Participation rates are even lower for female and minority patients and those who live outside metropolitan areas or in lower income urban areas.^{59, 60} Research also indicates that cardiac rehabilitation is associated with lower all-cause mortality rates in patients with diabetes, however patients with diabetes have lower participation rates than the non-diabetes population.⁶¹ For these reasons, it is essential that Congress increase access to these vital services.

Improving Accountable Care Organizations

The Medicare Shared Savings Program (MSSP) is an important component of Medicare, which saved more than 1.8 billion dollars in 2022.⁶² Over 140,000 NPs are participating in MSSP ACOs, providing critical services to millions of Medicare beneficiaries within the program.⁶³ However, statutory requirements⁶⁴ still exist which

⁵¹ <https://www.aana.com/comment-letter/aarp-endorsement-of-i-can-act-hr-2713>.

⁵² <https://www.cdc.gov/heartdisease/about.htm>.

⁵³ Birger M, Kaldjian AS, Roth GA, Moran AE, Dieleman JL, Bellows BK. Spending on Cardiovascular Disease and Cardiovascular Risk Factors in the United States: 1996 to 2016. *Circulation*. 2021 Jul 27;144(4):271–282. doi: 10.1161/CIRCULATIONAHA.120.053216. Epub 2021 Apr 30. PMID: 33926203; PMCID: PMC8316421.

⁵⁴ <https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-mortality>.

⁵⁵ <https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-burden>.

⁵⁶ <https://millionhearts.hhs.gov/data-reports/factsheets/cardiac.html>.

⁵⁷ <https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.119.005902>

⁵⁸ <https://www.atsjournals.org/doi/10.1513/AnnalsATS.201805-332OC>.

⁵⁹ Li S, Fonarow GC, Mukamal K, Xu H, Matsouaka RA, Devore AD, Bhatt DL. Sex and Racial Disparities in Cardiac Rehabilitation Referral at Hospital Discharge and Gaps in Long-Term Mortality. *J Am Heart Assoc*. 2018 Apr 6;7(8):e008088. doi: 10.1161/JAHA.117.008088. PMID: 29626153; PMCID: PMC6015394.

⁶⁰ Castellanos LR, Viramontes O, Bains NK, Zepeda IA. Disparities in Cardiac Rehabilitation Among Individuals from Racial and Ethnic Groups and Rural Communities—A Systematic Review. *J Racial Ethn Health Disparities*. 2019 Feb;6(1):1–11. doi: 10.1007/s40615-018-0478-x. Epub 2018 Mar 13. PMID: 29536369.

⁶¹ <https://www.ahajournals.org/doi/10.1161/JAHA.117.006404>.

⁶² Medicare Shared Savings Program Saves Medicare More Than \$1.8 Billion in 2022 and Continues to Deliver High-quality Care. CMS. <https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high>.

⁶³ <https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results/data>. (January 2022 Performance Year Financial and Quality Results).

⁶⁴ Social Security Act Section 1899(c)(1).

require a beneficiary to receive a primary care service from a physician as a pre-step before they can be assigned to a MSSP accountable care organization (ACO). This requirement inhibits the ability of Medicare to equitably provide accountable care, and limits the participation of patients who see NPs as their primary care providers. **Therefore, we strongly support the passage of the ACO Assignment Improvement Act of 2024 (S. 3939) which would address this barrier and fully include NPs and their patients in the MSSP.**

We appreciate that in the 2024 Medicare Physician Fee Schedule final rule, CMS updated the MSSP to better include patients seen by NPs, and better align beneficiaries with the clinician who is providing their care.⁶⁵ The CMS analysis of this expansion of the assignment methodology to better account for NPs' patients notes that the changes would add a population of patients who have been historically underrepresented in the MSSP.⁶⁶ This includes those with a disabled Medicare enrollment type, those residing in areas with a slightly higher average ADI national percentile rank, and a larger share of Medicare Part D LIS enrollment. This is consistent with the June 2022 MedPAC report which found that, among all clinician types, NPs on average had the highest share of allowed charges associated with low-income subsidy (LIS) beneficiaries. "In 2019, 41 percent of the allowed charges billed by NPs who practiced in primary care were for LIS beneficiaries, as were 36 percent for NPs who practiced in specialty care compared with 28 percent for primary care physicians and PAs and 25 percent for specialty care physicians and PAs."⁶⁷

In its FY 2021 Budget in Brief, HHS stated that basing ACO-assignment on a broader set of primary care providers, including NPs, better reflects our current primary care workforce and would lead to \$80 million in savings for the Medicare program over 10 years.⁶⁸ However, statutory barriers still need to be fixed in order to fully include NPs and their patients in the program. **Therefore, we respectfully request the Committee include S. 3939 in any legislative efforts pursuant to this hearing in order to fully include NPs and their patients in the MSSP.**

Creation of a Medicare Payment Technical Advisory Committee

During the hearing, Senator Whitehouse and witness Dr. Amol Navathe discussed the importance of establishing a technical advisory committee to help CMS more accurately determine fee schedule rates. We appreciate the Committee's attention to this matter, and firmly believe that reform is needed for the current valuation process. The historic issues with undervaluation of primary care services are directly aligned with the issues within the overall valuation process. Therefore, the process must be reformed to improve accuracy and ensure the updates are regular and comprehensive. These reforms must include a CMS technical advisory committee which is inclusive of all health care providers billing the Medicare program.

Multiple official reports from government agencies and MedPAC have identified serious flaws with the current process, and CMS' valuation of services. In May 2015, the United States Government Accountability Office (GAO) issued a report to Congressional Committees on *Medicare Physician Payment: Better Data and Greater Transparency Could Improve Accuracy*.⁶⁹ In this report, GAO states that "CMS's process for establishing relative values embodies several elements that cast doubt on whether it can ensure accurate Medicare payment rates and a transparent process."⁷⁰ The report identifies numerous flaws within the process and concludes that "CMS's process for establishing relative values embodies several elements that cast doubt on whether it can ensure accurate Medicare payment rates and a transparent process."⁷¹ GAO also noted that "in the majority of cases, CMS accepts the RUC's recommendations and participation by other stakeholders is limited"⁷² and that

⁶⁵ P. 961 2024 PFS Final Rule. <https://public-inspection.federalregister.gov/2023-24184.pdf>.

⁶⁶ 88 FR 52440. <https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicare-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other>.

⁶⁷ medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf (Page 135).

⁶⁸ HHS. <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf> (hhs.gov) (page 84).

⁶⁹ GAO-15-434, Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy. <https://www.gao.gov/assets/gao-15-434.pdf>.

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

⁷² *Ibid.*

“Given the process and data related weaknesses associated with the RUC’s recommendations, such heavy reliance on the RUC could result in inaccurate Medicare payment rates.”⁷³ As noted in the GAO report, “the reliability of work relative value recommendations may be undermined by survey respondents’ potential conflicts of interest.”⁷⁴

These inherent conflicts in the valuation process led to a historic undervaluation of E&M services, which are a foundational aspect of the primary care system. The resulting negative impact on Medicare beneficiaries was identified in MedPAC’s 2018 Report to the Congress *Medicare and the Health Care Delivery System*. Chapter 3 of this report, stated that “this mispricing may lead to problems with beneficiary access to these services” which are “essential for a high-quality, coordinated health care delivery system.”⁷⁵ The report states that “to estimate clinician work time for specific services, CMS relies on data from surveys conducted by specialty societies that are reviewed by the RUC. We have concerns about these data; for example, the surveys have low response rates and low total number of responses, which raises questions about the representativeness of the results.”⁷⁶ The Commission stated that the systemic undervaluation of E&M services was partially “because the fee schedule is budget neutral, ambulatory E&M services become underpriced through a process of passive devaluation.”⁷⁷

From 2011 to 2015, CMS agreed 69% of the time with the valuations set by the RUC.⁷⁸ GAO highlighted the inherent conflict in their report, noting that “stakeholder participation in CMS’s process is limited because of incomplete information regarding which services are undergoing RUC—and eventually CMS—review.”⁷⁹ In its 2015 report, GAO recommended “to help improve CMS’s process for establishing relative values for Medicare physicians’ services, the Administrator of CMS should incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by the Protecting Access to Medicare Act of 2014.”⁸⁰

In a 2022 update, GAO noted that “to close this recommendation, we need documentation that CMS has started to incorporate data more broadly into its process for establishing relative values and that it has a documented timeline and plan for how it will use the funds appropriated by the Protecting Access to Medicare Act of 2014. As of December 2022, we had not received this documentation.”⁸¹ Therefore, as the Committee considers action on reimbursement, we support the establishment of a technical advisory panel, which is aligned with the recommendation from GAO.

Conclusion

We appreciate the Committee’s recognition of the need to address the structural inequities within the Medicare program which inhibit beneficiary access to coordinated, whole-person, patient-centered care. NPs are inequitably reimbursed for the care they provide to Medicare patients and still face barriers to participation in the program, despite the essential value that they provide in maintaining access to high-quality care for Medicare beneficiaries. We look forward to working with the Committee on improving and modernizing the Medicare program to reflect the current health care workforce and to meet the needs of Medicare beneficiaries.

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On behalf of its 39,000 orthopaedic surgeon members, the American Association of Orthopaedic Surgeons (AAOS) is pleased to submit this statement for the record of

⁷³ *Ibid.*

⁷⁴ *Ibid.*

⁷⁵ *jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf.*

⁷⁶ *Ibid.*

⁷⁷ *jun18_ch3_medpacreport_sec.pdf.*

⁷⁸ GAO-15-434, Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy. <https://www.gao.gov/assets/gao-15-434.pdf>.

⁷⁹ *Ibid.*

⁸⁰ Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy, U.S. GAO. <https://www.gao.gov/products/gao-15-434>.

⁸¹ *Ibid.*

the April 11, 2024 hearing, “Bolstering Chronic Care through Medicare Physician Payment,” before U.S. Senate Committee on Finance. We share the committee’s goal of preserving patient access to care by reimbursing physicians appropriately under Medicare. Given ongoing concerns about increased consolidation and vertical integration in healthcare that the committee highlighted in a separate hearing last summer, it is critical that Congress take this opportunity to get Medicare payment reform right.

Consolidation Trends in the U.S. Health Care System

Consolidation is inextricably linked to Medicare payment policy, as declining physician reimbursements often fail to cover the skyrocketing cost of practicing medicine. As a result, small independent physician practices are being pushed to their financial brink and forced to merge with massive healthcare conglomerates and larger hospital systems. Ultimately, it is our patients who are most negatively impacted by this trend, as it has been well established that consolidation has not led to improved health of patients and often leads to higher costs and decreased patient choice.¹ The stress of running a medical practice, including amplified financial pressures and administrative burdens, is causing one in five physicians to consider leaving private practice within 2 years.² Unfortunately, the negative impact of the rising costs of running a medical practice disproportionately impacts small, independent practices, rural physicians, and those serving low-income and marginalized communities increasing the risk of access to care issues for some of our country’s most vulnerable patients who are most in need of chronic care.

Despite promises of increased productivity and reducing redundancies, consolidation has not resulted in the lower costs and better care promised by the massive U.S. health care systems. Rather, research shows that increased consolidation has led to higher health care prices across the board. The consolidation of practices and integration with hospital systems can lead to increased prices for common orthopaedic procedures and decrease competition and opportunities among independent practices in the same market. For example, the cost for knee replacement and lumbar spine fusion were approximately 30 percent higher in concentrated markets versus competitive markets.³ This data amplifies the concerning trend that consolidation has consistently led to higher costs for patients and payers, undermining affordability and access to care.

Stabilizing Medicare Reimbursement for Physicians

Our nation’s physicians are currently grappling with yet another cut to the Medicare Physician Fee Schedule (MPFS). Coupled with medical practice costs which are projected to increase by 4.6% this year, even the reduced cut of 1.69% that Congress implemented in its recent appropriations package is financially straining physician practices past their breaking point.

While the gap between rising physician costs and stagnant or declining reimbursement has grown more volatile in recent years, the economic uncertainty it creates for physicians has been slowly building for decades. The projected 4.6% increase clinicians’ input costs for CY 2024—as measured by the Medicare Economic Index (MEI)—is the highest it’s been this century, beating last year’s record of 3.8%. In fact, since 2001, the cost of running a medical practice has increased 39%, but the Centers for Medicare & Medicaid Services (CMS) has only increased reimbursement for physicians by 11%.⁴ Unlike hospitals and nursing homes—physicians and other health care professionals do not receive an automatic increase to help keep up with the rate of inflation. As a result, when adjusting for inflation in practice cost, Medicare physician pay dropped by 20% over the past 2 decades.⁵

Given this economic climate, it should come as no surprise that many practices are forced to choose between closing their doors or consolidating with larger healthcare institutions that can provide the kind of economic stability needed to continue treating patients. Increasing physician reimbursement to keep pace with hospital reimbursement is one very tangible way that Congress can alleviate the economic conditions that lead to consolidation and ultimately higher costs for health care. Providing physicians with a full inflationary update tied to MEI is a necessary first

¹ <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>.

² [https://www.mcpiqojournal.org/article/S2542-4548\(21\)00126-0/fulltext](https://www.mcpiqojournal.org/article/S2542-4548(21)00126-0/fulltext).

³ JC Robinson. Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology. *Am J Managed Care* 2011; 17(6):e241–e248.

⁴ <https://www.ama-assn.org/system/files/medicare-pay-chart-2021.pdf>.

⁵ <https://www.ama-assn.org/sites/ama-assn.org/files/2022-09/medicare-updates-inflation-chart.jpg>.

step to further stabilize the MPFS. For this reason, we urge Congress to pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which would accomplish this goal.

Budget Neutrality

Physicians are not only struggling to keep up with inflation, but they also face Medicare reimbursement cuts year-after-year due to budget neutrality constraints. The Omnibus Budget Reconciliation Act of 1989 contained a provision which mandated that any upward payment adjustments or the addition of new procedures that will increase spending by \$20 million or more must be offset by cuts elsewhere in the MPFS. As a result, the various medical specialties are pitted against each other in competition over the size of their respective pieces of the MPFS pie, creating even more uncertainty for physicians. It is not uncommon for a physician in one specialty to see their payments reduced because of policy decisions aimed at a completely different specialty that have little to do with their day-to-day practice of medicine. In fact, roughly 60% of the original 3.37% cut that CMS proposed in this year's MPFS can be attributed to one such policy decision—the implementation of the G2211 add on code that is primarily directed towards primary care and other office/outpatient evaluation and management (E/M) intensive specialties.

The idea that physicians must compete against each other for fewer and fewer resources is completely antithetical to the team-based, patient centered approach that is so vital to chronic care. Rather than promoting the kind of collaborative, cooperative environment necessary to coordinate care for patients with chronic conditions across multiple specialties, the current payment reimbursement reinforces a zero-sum view of delivering healthcare, where one specialty's reimbursement bump is another specialty's loss. A good first step would be to raise the MPFS budget neutrality threshold and index it to inflation going forward, as well as providing statutory guard rails to limit the year-over-year changes to the conversion factor (CF).

Unless we make long-term, structural changes to how Medicare—and by extension, how the rest of the private market, which often adjusts its rates based on changes to Medicare—values the services physicians provide, the idea of the independent, private practice physician will continue to fade from our health care system. For that model of health care delivery to be a financially viable option for physicians, they must have some sense of long-term financial security that the current patchwork of yearly payment fixes fails to provide to those who aren't salaried employees of a larger institution. While we appreciate Congress' efforts to mitigate the annual cuts, short-term legislative fixes only kick the can down the road without addressing the underlying stability. Next year, when both the 1.25% statutory adjustment from the Consolidated Appropriations Act, 2023 and the additional 1.68% relief from this year's appropriations package are set to expire, physicians are set to face yet another cut of 2.93% for 2025.

AAOS is supportive of legislation led by Reps. Greg Murphy (R-NC), Brad Wenstrup (R-OH) and Michael Burgess (R-TX), "The Provider Reimbursement Stability Act of 2023," which would reform budget neutrality and provide much needed stability within the MPFS for orthopaedic surgeons and the larger physician community. As written, the legislation would provide a full inflationary update to the MPFS and limit positive or negative adjustments to Medicare reimbursements to 2.5 percent. AAOS believes this legislation is another great step that Congress can take towards more comprehensive payment reform.

Specialists' Role in the Transition to Value-Based Care

The original intent of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—to incentivize the shift of U.S. healthcare spending and delivery from a fee-for-service model to a value-based care model—has been successfully implemented in some respects. However, it has failed to create the abundance of opportunities for physicians to participate in alternative payment models (APMs) that are necessary to make the program successful.

As it relates to orthopaedic surgery, a shift to value-based models has proven to be complicated and costly with limited return on investment. Physicians are overloaded with administrative burden to comply with the numerous value-based payment models and patients are often unaware that they are participating in such arrangements, thus limiting the effectiveness of such programs.

When considering the goals of MACRA, it is important to return to the intent of the law and explore options for providing care in a way that is of high value while remaining accessible to all patients. This may look like a single system for designing and operating all value-based payment models, with one platform for measure test-

ing, approval, and use, as well as the same single platform for submission. Such a platform would be compatible with both government-operated and privately-operated value-based care programs.

AAOS is supportive of advancing value-based care and developed a value-based care continuum (VBCC) to help orthopaedic practices better understand and navigate various alternative payment models created to achieve value-based care. AAOS also supports the creation of voluntary, physician-led alternative payment models that expand access to quality specialty care through wraparound approaches to musculoskeletal disorders. This includes care teams that assess the clinical and social factors that make surgical and nonsurgical interventions safe, effective, and long-lasting. Orthopaedic surgeons should remain the foremost leaders of these care teams which may include mid-level practitioners, nurse navigators, and physical therapists. Essential to improved access is reduced administrative burden which detracts from time spent with the patient and slows the treatment process.

AAOS members are eager and willing participants in the transition to value-based care and were early adopters of value-based payment models, participating in the now partially mandatory Comprehensive Care for Joint Replacement (CJR) and voluntary Bundled Payments for Care Improvement-Advanced (BPCI-A) programs. Our members' work to optimize patient care, increase value, and decreased costs resulted in an estimated \$61.6 million estimated net savings in the first three performance years of the CJR program.⁶

Any legislation passed by Congress must support surgeon-led models, which are highly effective at achieving participation from physicians, savings to the Medicare program, and patient engagement in their care.

Congress clearly demonstrated its commitment to surgeon-led models when it created the Physician-focused Payment Model Technical Advisory Committee (PTAC) to review and recommend stakeholder-designed APM proposals. However, the committee has been plagued by years of turmoil and resignations in protest of HHS' failure to adopt any of its recommended models.⁷ In fact, PTAC has evaluated more than three dozen models and recommended several to HHS and CMS, but none have been adopted.

The problems with PTAC point to a broader issue with how CMS has been exploring and evaluating options for alternative payment models and cost savings in health care. Just last month, the Congressional Budget Office issued a report estimating that the Center for Medicare & Medicaid Innovation (CMMI)—the agency tasked with testing new APMs and identifying potential cost savings—actually increased federal spending by \$5.4 billion between 2011 and 2020, and will continue to increase net spending by \$1.3 billion over the next decade. The spending increase is a result of CMMI's failure to identify and expand models that produce cost savings. The agency spent \$7.9 billion to operate models between 2011 and 2020. Of the 49 models it initiated, only 6 “generated statistically significant savings” and only 4 have been “certified for expansion” by CMS and HHS.

As Congress considers ways to improve the pipeline of viable APMs, particularly for specialty care, it should explore ways to bolster the role of PTAC and give surgeons real input in developing and implementing models that best suit the needs of their patients.

CMS has taken the initiative to create and support Accountable Care Organization (ACO) models, which is a significant step in moving the United States toward a population health approach to care. Ultimately, we all want to create and participate in a model that helps patients achieve good health outcomes and enable us to sustainably care for our rapidly growing Medicare population. However, the current models are designed to place the risk and cost management aspects of value-based payments solely in the realm of primary care practitioners while keeping the specialists and their teams in the fee-for-service world. This is based on the premise that ACOs will be able to identify and refer patients to high value specialists while providing most of the care themselves.

Given the proportion of Medicare dollars spent on specialty care and the prevalence of conditions that are treated by specialists, this is a recipe for failure. The AAOS strongly recommends an approach that allows risk sharing downstream with the specialists who provide care for these conditions. Providing efficient, evidence-based

⁶ <https://innovation.cms.gov/data-and-reports/2022/cjr-fg-thirdannrpt>.

⁷ <https://www.politico.com/newsletters/politico-pulse/2019/11/25/a-closer-look-at-medicare-for-all-783041>.

treatments for musculoskeletal conditions with an eye toward preventive care and improving overall health can only be accomplished with deep and expansive expertise in the most prevalent health conditions. To achieve the shared savings that CMS aims for, it mandates that the experts who work directly with patients on key decision making are incentivized toward value. The most promising model to facilitate ACO/Specialist collaboration is a condition-based payment mechanism as described in the attached white paper developed by AAOS volunteers and staff. Thus, AAOS urges the Center for Medicare and Medicaid Innovation (CMMI) to explore and immediately pilot a program for the management of chronic, prevalent conditions such as osteoarthritis of the knee, as delineated, with plans to expand into other conditions as the reconciliation, monitoring, and payment mechanisms are refined from this initial experience.

Key factors that drive improvements in cost, quality and outcomes are communication, collaboration, and the use of high-quality data to inform clinical decision making. Successful population health organizations maintain services to patients aimed at providing as much on site and well-rounded care as possible. This may cost more upfront for organizations but eventually help to avoid costly acute and post-acute care. Such interventions will inevitably result in more value-based revenue and more importantly, better outcomes and happier patients. By utilizing high quality data and metrics, primary care practitioners and their teams can adopt referral patterns that correspond to population health and value-based care goals. They will be able to identify and work with high quality, high performing specialists. This will decrease stress and time for referral appointments for the primary care while enhancing the patient's experience and trust in the population-based organization.

Engaging specialists in episodic care management also reduces the stress and strain on primary care. No single physician can know and understand best practices for the management of every disease. By engaging specialists who are familiar with best practices for any given disease process, time and costly interventions can often be avoided. To share an example, it is quite common for a patient to have waited a lengthy period to be seen in an orthopaedic practice. They usually present in pain and frustrated with an MRI that is positive for meniscal tearing amid extensive osteoarthritis and their expectation is that arthroscopic surgery will heal their meniscal tear. In such a scenario, by engaging orthopaedic surgeons and other musculoskeletal specialists earlier in the process the patient would be more satisfied that their needs and fears were being addressed, the unnecessary MRI would be avoided, the patient would be reassured that arthroscopy is not indicated for meniscal tears in the setting of osteoarthritis and that by undergoing physical therapy and other non-operative measures they could potentially postpone or obviate the need for total knee arthroplasty. Thus, saving the system money and further enhancing the patient's experience with improved health outcomes.

We urge you to consider the profound impact that interoperability, multi-payer alignment of measures, and administrative burden have on the ability for physicians to successfully participate in alternative payment models. It is incumbent upon Congress and CMS to ensure that these perennial barriers are resolved in any future model. Likewise, AAOS strongly encourages the agency to only consider voluntary models that have incentives for participation. Mandatory models have historically been unsuccessful in engaging physicians who are otherwise eager to lead in the shift to value-based care. As in our earlier comments on the Comprehensive Care for Joint Replacement (CJR) Model and subsequent extension, a mandate to include all episodes, physicians, and facilities in a designated Metropolitan Statistical Area severely disadvantaged those surgeons, non-physician providers, and facilities that either did not have the proper infrastructure to optimize patient care under episodes-of-care payment models and/or lacked adequate patient volumes to create sufficient economies of scale. A voluntary program that allows surgeons, facilities, and non-surgical providers to tailor their episode-of-care models to their unique patient population would lead to far better patient outcomes as well as more accurate and efficient payments.

In conclusion, the American Association of Orthopaedic Surgeons urges Congress to take immediate action to address the growing challenges facing physicians and their patients in the U.S. healthcare system. By stabilizing Medicare reimbursement, reforming budget neutrality, and supporting the development of physician-led alternative payment models, Congress can help to reverse the trend of consolidation, preserve patient access to care, and promote the transition to value-based care. We stand ready to work with the Committee and other stakeholders to advance these critical priorities and ensure that our nation's healthcare system remains robust, innovative, and patient-centered for years to come. Thank you for the opportunity to

submit this statement for the record, and we look forward to continuing to engage with the Committee on these important issues.

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April 25, 2024

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
Washington, DC

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC

Dear Chair Wyden and Ranking Member Crapo:

On behalf of the American Clinical Neurophysiology Society (ACNS), we appreciate the opportunity to provide input on the Senate Finance Committee's April 11th hearing on "Bolstering Chronic Care through Medicare Physician Payment." We appreciate that Senators raised issues related to the Medicare conversion factor, prior authorization, and quality programs and we look forward to working with the Committee and the bipartisan working group on legislative solutions to these issues.

Founded in 1946, ACNS is a professional society with more than 1,500 members comprised of physicians, researchers and allied health professionals devoted to the establishment and maintenance of standards of professional excellence in clinical neurophysiology under the practice of neurology, neurosurgery, and psychiatry. ACNS members utilize neurophysiology techniques in the diagnosis and management of patients with disorders of the nervous system and in research examining the function of the nervous system in health and disease.

Clinical neurophysiology is a neurology subspecialty. ACNS members focus attention not just on electroencephalography (EEG), but also on evoked potentials, electromyography, nerve conduction studies, neurophysiologic intraoperative monitoring, polysomnography and other sleep technology, quantitative neurophysiological methods, magnetoencephalography, sleep disorders, epilepsy, neuromuscular disorders, brain stimulation, brain-computer interfacing, and related areas. Many of the patients we treat are Medicare beneficiaries; consequently, an effective Medicare payment system is of particular importance to our members.

While we appreciate the challenges of primary care, we want to note that the patients with chronic conditions that our members treat require long-term specialized care; indeed, ACNS members are the medical home for patients with epilepsy a very common chronic neurological condition, amongst others such as chronic neuromuscular diseases. The solutions that the Committee develops should not be limited to primary care but should support those physicians who manage patients' complex, and often chronic, conditions, and we offer the following recommendations as the Committee continues its work.

Recommendations to Improve the Medicare Payment System

Creating reimbursement stability must be a high priority for Congress as you develop legislation to revise the payment system. We believe that the current system is broken and unsustainable for Medicare beneficiaries and providers. Each year the threat of cuts to physician payments creates uncertainty and anxiety for physicians, who already feel overwhelmed and undervalued. We already see workforce shortages across specialties, including neurology where increasingly a dwindling workforce takes care of an ever-expanding demographic of elderly patients. Neurologists develop longitudinal relationships with their patients to manage their complex health conditions.

As you know, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 eliminated the SGR's volume-based targets, which resulted in annual decreases to the conversion factor; often Congress stepped in to avert those required cuts. However, due to the retention of the Physician Fee Schedule's statutory budget neutrality requirement and lack of conversion factor updates, the last of 0.5 percent update was applied in 2020, physicians again face significant payment cuts requiring Congress to intervene. Under the SGR and MACRA, Medicare physician payment

has stagnated for the last 2 decades. Physicians have struggled to keep pace as practice costs, the consumer price index, and other factors have kept physician payments flat. Meanwhile, hospital inpatient and outpatient reimbursement, which include a mechanism for regular updates, have increased at a steady pace.

ACNS would support the development of a stable Medicare payment system that eliminated the threat of yearly payment cuts, while also keeping payments on pace with inflation and creating increases that were on par with other payment systems under Medicare. Barriers to care will worsen if the stability of maintaining a livelihood as a physician remains threatened.

We believe that MACRA cannot be fixed without eliminating or adjusting the budget neutrality requirement. While Congress and CMS would like to transition to value-based payment models, it likely cannot be done without increases to physician payments, given that the costs of practicing medicine are increasing. Costs such as investment in electronic health records, staff training, staff compensation, supplies and other items needed to operate a practice are increasing with inflation, yet physician payment remains flat.

The payment system cannot be updated or fixed unless the system provides for regular updates to the underlying practice expense inputs. Specifically, the indirect practice expense inputs of operating a medical practice used in the calculation of physician payments for Medicare services indirect are derived from survey data that is 16 years old. We believe that regularly updating the direct and indirect practice expense is a key component of a stable Medicare payment system that will include increases that are proportionate to economic changes.

CMS is aware that the Medicare Economic Index (MEI) weights need to be updated. CMS had proposed to update the MEI using 2017 data from the United States Census Bureau's Service Annual Survey but ultimately decided not to make this change in CY 2023 due to the significant redistributive effect of the policy. We implore Congress to work with CMS to update the MEI and develop a mechanism to keep it current.

In addition to revising the budget neutrality adjustment, we believe that the compliance and reporting requirements of the Quality Payment Program (QPP) are extremely complex despite Congress' intention to simplify quality reporting requirements under MACRA. The QPP includes two separate, but equally complex payment systems—MIPS and advanced APMs; however, MIPS is not significantly more streamlined than the programs it was intended to replace. Congress must strive to revise the QPP such that its requirements support the delivery of truly value-based care and improved quality and do not create new check the box exercises or administrative burden. Even though the program was created to streamline quality reporting and to simplify it, many practices hire staff simply to assist with meeting the reporting requirements.

Additionally, MACRA's statutory requirements have impeded Congress' goals for the program. For instance, MACRA legislation dictated the weights of the different MIPS categories—quality, cost, promoting interoperability, and improvement activities. While the cost category now comprises 30 percent of the physician's MIPS score, we believe it does not accurately reflect a physician's performance. Measuring the cost of physician care must be attributed appropriately, and account for factors that are under the control of the physician. We encourage Congress to take this into account when considering revisions to the quality payment program.

Recommendations to Increase Provider Participation in Value-based Payment Models

As you know, value-based care models were created to tie payment for healthcare services to the quality of the care provided and not simply the volume of care delivered, while rewarding physicians for efficiency and effectiveness. However, the programs created under CMS have created challenges for physicians and physician practices that do not translate into value.

There is an increased administrative burden and financial risk involved with participation in value-based payment models. There is a significant investment in training staff at a time when there are staffing shortages and high turnover rates. This training often takes away time and resources that should be devoted to patient care. In addition, with so many variations in practices, including practice size, specialty type, practice location, and population demographics, a one-size fits all model simply does not work. Flexibility is key to provider participation as a model that is not adaptable will not take hold. We also believe that payment models should decrease the risk to the provider by limiting the penalty for those items out of control of the

provider (such as when a patient cannot afford a medication or does not have access to transportation to attend appointments).

In summary, value-based payment models need to be tailored to specialties and subspecialties, with associated meaningful quality measures, and those payment models need to be easy for the provider to enroll and navigate.

Recommendations to Improve MIPS and APM Programs

To improve the MIPS program, CMS needs to have the authority and resources to create programs that are meaningful to all providers and patients regardless of specialty type, while lowering the burden to participate in these programs. We understand the constraints under the current payment system. We believe that collaboration with stakeholders will assist in creating more meaningful programs.

ACNS also believes there needs to be more meaningful quality measures created for specialties. Often our members report on measures that have little impact on the care provided, and providers may simply be fulfilling administrative requirements. We would welcome the opportunity to work with CMS and other stakeholders to create meaningful, actionable measures for our specialty.

We also would like to see a quality program that produces measured feedback that is timely and actionable. At present, we do not believe that some of the information found in performance reports is relatable to our practice patterns. Finally, many of the quality measures do not focus on patient care and outcomes, therefore we again encourage CMS and other stakeholders to consider creating more meaningful measures.

We would also recommend simplifying the reporting requirements and reporting tools used in quality programs, while aligning rules and administrative tasks across programs. In addition, we believe that providers need more meaningful and useful educational resources so that we are better equipped to meet the demands of quality payment programs.

Recommendations on Reducing the Burden of Prior Authorization

Prior authorization is a major barrier to the delivery of timely care and treatments to patients and resulting in additional administrative burdens for providers. People with chronic illnesses such as epilepsy often experience prior authorization issues when accessing care. For example, prior authorization requirements make it difficult to schedule appointments for the Epilepsy Monitoring Unit (EMU). Our providers are not able to receive prior authorization until the day of the scheduled procedure, leaving no time to adequately counsel the patient on the procedure or the cost of the service. If the prior authorization is denied, the patient faces the difficult choice of going forward with the procedure or rescheduling, which may not be medically advisable. This also may strain the patient-provider relationship, which hinders the practice of medicine.

Those staff responsible for approving prior authorizations often lack the expertise on the areas of medicine that our members practice, which can cause additional barriers to care. For example, a children's hospital treating a pediatric patient with potential catastrophic epilepsy may seek prior authorization for a procedure called a hemispherectomy, the removal of half of a patient's brain. After significant delay, the insurer approves the prior authorization for the hemispherectomy but states that a separate authorization would have to be given for performing the procedure on the other half of the brain. The decision makers did not have the expertise to understand that you would not perform two hemispherectomies on the same patient, which took additional provider time to explain to the insurer. It would reduce the burden on providers if there were subject matter experts reviewing the prior authorization request to ensure timely and appropriate authorization.

Thank you again for the opportunity to provide our feedback as the Finance Committee develops legislation to address physician payment and improve care for patients with chronic conditions, such as epilepsy. We look forward to working with the Committee and the bipartisan working group led by Senators Stabenow and Thune as this process moves forward. Please reach out to Stefanie Rinehart at srinehart@dc-crd.com with any questions.

Sincerely,

Meriem Bensalem-Owen, M.D., FACNS
President

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April 16, 2024

Hon. Ron Wyden
 Chair
 U.S. Senate
 Committee on Finance
 221 Dirksen Senate Office Building
 Washington, DC 20510

Hon. Mike Crapo
 Ranking Member
 Senate
 Committee on Finance
 239 Dirksen Senate Office Building
 Washington, DC 20510

RE: ACAAI Statement for the Record in Response to U.S. Senate Committee on Finance Committee Hearing: Bolstering Care through Medicare Physician Payment—Thursday, April 11, 2024

The American College of Allergy, Asthma, and Immunology's (ACAAI's) Advocacy Council appreciates the Senate Committee on Finance holding a hearing on improving chronic care through Medicare physician payment. We hope this hearing highlighted the insufficiency of Medicare reimbursement for physicians who care for patients with chronic conditions.

ACAAI represents more than 6,000 board-certified allergists and healthcare professionals. Allergists specialize in treating both adult and pediatric patients with chronic conditions such as asthma, food allergies, hives or urticaria, stinging insect hypersensitivity, sinus problems, allergic rhinitis, anaphylaxis, immune deficiencies, and atopic dermatitis or eczema, among other things.

Chronic conditions generally cannot be cured. They require ongoing care from a trusted and skilled clinician to effectively manage the patient's condition. Chronic care for a condition such as asthma requires regular office visits and medication adherence and management. Modern technology makes it possible to track symptoms outside of the exam room and allows patients to communicate with clinicians more regularly through portal messages. The current reimbursement model does not adequately account for these advances. Improvements are needed so that clinicians are reimbursed in a way that incentivizes care management and supports modern clinical approaches to chronic care management.

Recent policy changes such as revised evaluation and management (E/M) code values and documentation requirements have helped allergy practices receive more adequate reimbursements. However, more is needed.

Overall, we agree with many of the key issues brought up in the hearing, including low physician payments, the fragmented system of services produced by the Physician Fee Schedule, and the lack of meaningful value or clinical relevance in the metrics used in value-based payment programs such as the Medicare's Merit-Based Incentive System (MIPS).

The ACAAI agrees with the Finance Committee that physician payment reform is necessary to improve treatment for patients with chronic conditions. To achieve this goal, ACAAI recommends:

- **Permanently preventing various Medicare reimbursement reductions from taking effect at the start of each calendar year.** ACAAI is appreciative of Congress' efforts to avert reductions to Medicare reimbursement rates, but the annual cycle of physicians advocating against cuts to the Conversion Factor to prevent Medicare reimbursement reductions highlights the need for a sustainable solution. We encourage the Senate to introduce and pass a companion version of Pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, and H.R. 6371, the Provider Reimbursement Stability Act of 2023.

Congress must permanently waive the 4% PAYGO reduction put into place when passing the American Rescue Plan of 2021. Moreover, the continuous extension of the 2% Medicare sequestration reduction, initially intended to be only for 10 years when it was implemented in 2011, has created an enduring challenge for healthcare providers. This reduction, in combination with the expiration of the MIPS exceptional performance bonus and other policies, has made it difficult for many allergists to receive meaningful Medicare reimbursement adjustments. Creating greater financial certainty for allergy practices is not just a solution but a lifeline for the healthcare workforce serving patients facing

chronic conditions, ultimately ensuring access to quality care for those who need it most.

- **Congress should pass S. 3805, No Fees for EFTs Act, which would close the EFT fee loophole by specifying that fees are prohibited for transactions occurring directly between health plans and providers, including EFT transactions facilitated on behalf of health plans by covered entities or third parties.** Additionally, Congress should prohibit automatic Virtual Credit Card (VCC) payments unless providers give advanced consent, effectively changing VCCs from opt-out to opt-in payment options. HIPAA has established a standard electronic transaction for Electronic Funds Transfer (EFT) payments to healthcare providers, promoting the transition away from paper checks. These EFT payments are akin to an employer directly depositing an employee's paycheck into their bank account and have been increasingly adopted, with 75% of claims payments utilizing the standard EFT transaction as of 2022. However, certain commercial payers exploit a loophole that allows them to charge healthcare providers additional fees for EFT transactions.

In addition, some commercial health plans attempt to reimburse physicians using Virtual Credit Cards (VCCs). These are electronic numbers provided to physicians for payment, similar to credit card transactions, but they often entail payment fees. Physicians should have the option to opt out of VCC payments and receive a standard EFT transaction, which is free of additional charges. However, the opt-out process can be administratively burdensome for healthcare practices, and the alternative EFT payment may also carry fees when facilitated by third-party payment vendors. While CMS can regulate HIPAA transaction standards, it lacks the authority to address VCC-related issues. Congress therefore needs to act to protect practices from VCC payment fees.

- **Simplifying Merit-Based Incentive Payments (MIPS) and Advanced Payment Models.** Value-based payments, while well-intentioned, can be burdensome for allergists treating chronic conditions. As currently constructed, programs such as MIPS require significant investment of resources to effectively participate but have limited opportunities for physicians to receive significant payment increases as a reward for this investment. Allergists would benefit from less burdensome and more meaningful requirements to succeed in these programs, with a reformed payment incentive system to increase the benefits of succeeding in value-based payment programs.

Additionally, physicians would have more success in value-based payment models if they were specifically tailored to the conditions they treat. We are disappointed that CMS has not tested any of the physician-focused payment models (PFPM) recommended by the PFPM Technical Advisory Committee (PTAC). In the MACRA legislation that created MIPS, Congress intended for PFPMs to serve as a physician-led alternative pathway to value-based care for chronic conditions to supplement MIPS and Advanced APMs. ACAAI's model, the Patient-Centered Asthma Care Payment Model,¹ was among the dozens of models that the PTAC recommended to CMS. Our model is an example of an innovative reimbursement model to reward effective chronic care management for asthma. Congress should direct CMS to dedicate a portion of CMMI's budget to implement PFPM recommended by PTAC.

- **Continuing bipartisan efforts to reform prior authorization, particularly in the Medicare Advantage program by reintroducing the Improving Seniors Timely Access to Care Act originally considered in the 117th Congress.** Requiring health plans to streamline their prior authorization processes will benefit physicians treating chronic care. Prior authorization, often used excessively by health plans, creates immense administrative challenges for physicians. It is essential that providers treating advanced chronic conditions, particularly amid widespread physician shortages, care for as many patients as possible. The barriers put in place due to prior authorization exacerbate challenges for patients with chronic conditions when accessing care.

While a recent CMS final rule implements much of this policy, gaps continue to exist. For example, the final rule for prior authorization does not apply to drugs. Medications are an essential component of a patient's chronic care management. Delaying a patient's access to their medication can disrupt their care.

¹ https://college.acaai.org/sites/default/files/Resources/Advocacy/apm_exec_summary-complete_model.pdf.

Congress should move to pass the Improving Seniors Timely Access to Care Act to help close these gaps. Congress should also further limit health plans' use of prior authorization and penalize plans for improperly denying claims. ACAAI also recommends that Congress explore a program that requires health plans to adopt a "fast-track" for physicians who have a high amount of their prior authorization claims approved.

- **Curtailling the influence of Pharmacy Benefit Managers (PBM) in dictating which medications treating chronic conditions (such as inhalers for treating asthma) are included in formularies.** To address and improve how physicians treat chronic care, they should be able to prescribe medications that, according to their expert opinion, would best improve the quality of life for someone living with a chronic condition. This is especially true for treating chronic conditions such as asthma where the popular and effective inhaler Flovent was recently removed from the market. Now, PBMs are refusing to include the cheaper, generic version on their formularies. The influence PBMs have on drug availability should be put into question, especially for treating chronic conditions. The Advocacy Council has endorsed the Senate Finance Committee's efforts to reform PBMs. We urge the Committee to continue its strong push to pass a law that would reign in the influence of PBMs and improve patient access to medications. We applaud the bipartisan efforts this committee has taken thus far to achieve this goal.

In conclusion, the ACAAI Advocacy Council expresses our deep appreciation for the Senate Committee on Finance's commitment to bolstering chronic care through Medicare physician reimbursement. Our recommendations span key areas, including reforming Medicare reimbursement, eliminating fees on electronic fee transfers (EFTs), and reigning in PBMs. We believe that these measures, if implemented, would go a long way in improving the care patients receive for their chronic conditions.

We look forward to working with the Committee to address these vital issues to ensure that allergy patients dealing with chronic conditions receive the care they deserve. Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com) if you wish to discuss our recommendations further. Thank you for your consideration.

Sincerely,

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April 24, 2024

Statement for the Record

On behalf of the 11,000 medical professional members of the American College of Lifestyle Medicine (ACLM) who are dedicated to treating and reversing lifestyle-related chronic disease, we would like to thank the Senate Finance Committee for holding its April 11th hearing "Bolstering Chronic Care through Medicare Physician Payment" and appreciate this opportunity to submit this Statement for the Record. As the nation's only medical professional association dedicated to such an approach to chronic disease, we wholeheartedly agree that chronic care needs bolstering—chronic disease creates human suffering among both adults and a growing number of children, lowered workforce productivity, clinician burnout, and financial unsustainability for families and the nation as a whole.

The incidence trajectory is alarming: According to the CDC, 51.8% of U.S. adults have at least one diagnosed chronic condition. Some 27.2% of U.S. adults suffer from multiple chronic conditions.¹ Chronic diseases are responsible for 7 out of every 10 deaths in the U.S., resulting in over 1.7 million fatalities annually. Accord-

¹ https://www.cdc.gov/pcd/issues/2020/20_0130.htm.

ing to NIH data² the adult obesity rate in 1980 in this country was 13.4%, and now stands at over 40%. This has led to similar large increases in the incidence of a wide range of comorbidities including cardiovascular disease, type 2 diabetes and pre-diabetes, chronic kidney disease and certain forms of cancer, most notably an increase in colon cancer among younger Americans. Only recently have we seen policy makers begin to call these comorbidities by their proper name: “diet-related chronic disease.”³

The financial impact is sobering: CDC reports 90% of the \$4.1 trillion in U.S. healthcare costs can be attributed to chronic or mental health conditions. Chronic disease accounts for 81% of all hospital admissions, 91% of all prescriptions filled, and 76% of all doctor visits. Furthermore, it’s estimated that employees with chronic conditions cost employers \$153 billion in lost wages each year.⁴ With the surge of demand for GLP-1 drugs and expansion of label usage, these costs will explode.

And the effect on society is unmistakable: Americans are living shorter, less healthy lives. According to recent a Commonwealth Fund report, The U.S. has an obesity rate nearly double the average of the 38 member countries of the Organization for Economic Cooperation and Development (OECD) with a life expectancy at birth 3 years lower on average and more than 7 years lower than leading member nations, all while spending nearly twice as much on health care per capita as any of them.⁵ As a result of its growing prevalence in the population, chronic disease now even threatens U.S. national security, affecting military recruitment eligibility and active-duty readiness. What’s more, it is a matter of health equity, as communities of color suffer more instances of chronic disease, face more social barriers to care such as transportation, and are vulnerable to more complication rates as a result, notably amputations.

As patient disease, suffering and the associated financial impact continues its unsustainable upward trajectory, the need for improved primary care payment is unquestionable. Physician burnout has created primary care physician shortages with yearly Medicare payments cuts only add to the workforce retention issue. The U.S. is already running low on primary care physicians, according to the American Medical Association, with an estimated shortage of between 17,800 and 48,000 predicted by 2034. The shortage of physicians has negative consequences for patients and communities, such as delays in access to care, poorer health outcomes, higher costs, and lower satisfaction.⁶ Nearly \$1 billion in annual excess health care expenditure are due to turnover of primary care physicians.

We believe taking steps to expand and reward the practice of lifestyle medicine is an absolutely necessary part of any strategy that hopes to stem this epidemic tide of chronic disease, improve patient outcomes, reverse the trend of physician burnout and contain the growth of health care spending in this country.

What is lifestyle medicine?

Lifestyle medicine is a medical specialty that uses therapeutic lifestyle interventions as a primary modality to treat chronic conditions including, but not limited to, cardiovascular diseases, type 2 diabetes, and obesity. Lifestyle medicine certified clinicians are trained to apply evidence-based, whole-person, prescriptive lifestyle change to treat and, when used intensively, often reverse such conditions. Applying the six pillars of lifestyle medicine—a whole-food, plant-predominant eating pattern, physical activity, restorative sleep, stress management, avoidance of risky substances and positive social connections—also provides effective prevention for these conditions.⁷

You will notice the word you do not find in that definition: manage. When most practitioners—and policy makers, for that matter—discuss chronic care that is the term they use, reflecting the belief that managing such conditions to ensure patients are prescribed and take their medications and care is coordinated to avoids gaps in

² <https://www.ncbi.nlm.nih.gov/books/NBK44656/#:~:text=The%20prevalence%20of%20obesity%20changed,children%20during%20the%20same%20period.>

³ [https://www.gao.gov/products/gao-21-593.](https://www.gao.gov/products/gao-21-593)

⁴ <https://news.gallup.com/poll/150026/unhealthy-workers-absenteeism-costs-153-billion.aspx#:~:text=WASHINGTON%2C%20D.C.%20%2D%20Full%2Dtime,billion%20in%20lost%20productivity%20annually.>

⁵ [https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.](https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022)

⁶ [https://www.msn.com/en-us/health/medical/where-have-all-the-doctors-gone-exploring-the-causes-and-consequences-of-the-physician-shortage-in-the-united-states/ar-AA1EeqZ.](https://www.msn.com/en-us/health/medical/where-have-all-the-doctors-gone-exploring-the-causes-and-consequences-of-the-physician-shortage-in-the-united-states/ar-AA1EeqZ)

⁷ [https://lifestylemedicine.org/about-us/.](https://lifestylemedicine.org/about-us/)

care that can result in hospitalizations and emergency rooms is the best we can do, that patients are consigned to having these conditions for life and the best we can do is slow the progression and mitigate the harmful side effects. ACLM and its members believes our health care system can and must do better.

To be clear, ACLM physicians are not anti-prescription drugs. Our members recognize the important role they play and often do prescribe such treatments. They simply do not believe they are the only or even the best answer for many patients. As ACLM member and practicing preventive cardiologist Cliff Morris described it, “Dr. Morris believes that in many instances medications are appropriate in maintaining the health of an individual; however, his goal is to treat the root cause of disease itself so the body no longer needs the medication, and thus does not have to live with the side effects of medications. If by adopting healthy lifestyle habits you can bring your numbers down naturally, then you will essentially no longer rely on the medication for your health. At that point, and only then, your provider will take you off of your medication. At Morris Cardiovascular we celebrate this moment as you take back your health.”

Despite wide recognition that all of this is directly related to significant dietary changes in our country and other lifestyle elements, the health care system has simply not evolved nearly enough to create a work force or payment systems equipped to address these conditions their patient populations most often present with. Most notably, our physicians receive little to no training in nutrition or exercise science in most of our medical schools and residency programs, with data showing that an overwhelming majority feel ill equipped to provide the kind of expert guidance their patients need in these areas.⁸ According to a recent article in STAT,⁹ “The average medical school student spends less than a day¹⁰ learning about obesity, despite the fact that over 40% of adults and 1 in 5 children¹¹ in the U.S. have it, according to some estimates.” The health care system did not cause this problem and there are major policy areas outside the system and the scope of the Finance Committee that need to be addressed, but the health care system does need to play a much larger and more direct role in addressing this epidemic if we are ever going to make real progress in improving outcomes.

This education and training does not need to be developed from scratch.

ACLM, which has championed food as medicine and other lifestyle “pillars” to address existing chronic disease since its inception in 2004, provides hundreds of hours of undergraduate, graduate (residency) and continuing medical education (CME) courses. We support student- and trainee-initiated Lifestyle Medicine Interest Groups at 132 academic and health institutions. Some 302 lifestyle medicine residency programs exist across 135 sites, with 6,900+ enrollees.

In support of the 2022 White House Conference on Hunger, Nutrition, and Health and to date, ACLM has committed \$44.1 million in complimentary coursework to 200,000 clinicians until September 2025, and lifestyle medicine certification support to one primary care provider in each of the nation’s ~1,400 Federally Qualified Health Centers.

We help prepare physicians and other clinicians for that certification. Since certification began in 2017 by the American Board of Lifestyle Medicine, 3,085 physicians in the U.S. have become board certified in lifestyle medicine, along with 1,263 other health professionals. Worldwide, across 72 countries, 5,017 physicians and 1,671 other clinicians are certified for a total of 6,688.

Lifestyle medicine training also has the ability to support better health behaviors for clinicians who are delivering care. One study, has shown that clinicians who practice LM are at a lower risk for burnout, which could help address the healthcare workforce shortages cited above.

The time for change in this area is long past due. The situation has become so dire, that in 2023, the American Academy of Pediatrics began recommending Intensive Health Behavior and Lifestyle Treatment (IHBLT) for children as young as 2 years old (while also recognizing that it is not “universally available”), obesity drugs for

⁸ <https://www.congress.gov/bill/117th-congress/house-resolution/784/text>.

⁹ <https://www.statnews.com/2023/03/20/childhood-obesity-guidelines-eating-disorders-data-concerns/>.

¹⁰ <https://www.wgbh.org/news/national-news/2023/01/31/scant-obesity-training-in-medical-school-leaves-docs-ill-prepared-to-help-patients>.

¹¹ https://www.cdc.gov/mmwr/volumes/67/wr/mm6706a3.htm?s_cid=mm6706a3_w.

children as young as 12 years old and bariatric surgery for children as young as 13 years old.¹²

Those same obesity drugs, glucagon-like peptide 1 (GLP-1) agonists, are changing the landscape of obesity treatment with demand surging and cost projections raising great concerns over their systemic impact on Medicare Part D costs, as well as their impact on Medicaid and commercial insurance costs. Even with Medicare statutorily precluded from covering GLP-1s for treatment of obesity, Ozempic alone was the sixth most costly Part D drug in 2022 with its indication only for treatment of type 2 diabetes.¹³ With recent FDA of approval¹⁴ of Wegovy for treatment of cardiovascular disease, the potential Medicare patient pool is likely to continue grow regardless of whether Congress takes action to allow Medicare to cover these drugs for obesity.

ACLM believes there is a role for the GLP-1s and is heartened by the positive short term impact they are having for patients not only in addressing obesity but also some of its most damaging comorbidities; however, given the high incidence of short term side effects, the potentially enormous systemic costs and the legitimate questions about the long term health effects to patients from taking appetite suppressants for a lifetime, we believe these drugs are best administered in combination with lifestyle medicine, to give patients a pathway to eventually no longer taking these drugs without quickly reversing the gains they have made. Again, the system is simply not equipped to offer that alternative right now with the rigor and at the scale that is required.

So what are the policy prescriptions we recommend the Finance Committee pursue to meet this goal of building a health care system equal to the challenge of addressing this epidemic and truly “Bolstering Chronic Care”?

As mentioned earlier, we believed it starts with dramatically increasing the time and quality of the nutrition education our doctors receive in Undergraduate Medical Education (UME) and Graduate Medical Education (GME). This was an area of focus at the 2022 White House Conference on Hunger, Nutrition and Health and the Department of Health and Human Services (HHS) has taken up the mantle as well, working with stakeholders like ACLM to drive desperately needed change in this area.

It is long past time for the Finance Committee to get involved in this as well. We recognize there are limits to how far Congress will go in dictating to schools and residency programs the content of their curriculum; however, there are clear steps the Committee can and must take to continue to help elevate this issue. We think that starts with the Committee simply holding hearings on the issue, bringing stakeholders such as that American Association of Medical Schools (AAMC) and the American Council for Graduate Medical Education (ACGME) up for questioning about what they are doing to address this glaring deficiency and, most importantly, an organization such as ACLM which is already offering scalable curriculum across the spectrum of medical education in this area. Given the number of hearings the committee has held to address issues related to chronic care such as the prices of the drugs used to treat the diseases, we think it is past time for the Committee to hold hearings on solutions that can reduce the need for those same medications.

The Committee could also legislate to require the Government Accountability Office (GAO) to report on the status of nutrition education in our residency programs, including best practices that the majority of residency programs are falling far short of in this area and could seek to replicate.

Along with creating a work force that is educated to work with patients to prevent and also to treat and reverse chronic conditions where possible, we also need payment models that incentivize models designed to reward physicians for taking such an approach. For instance, we have models where reducing hospitalizations is a quality measure. Why can't we also have quality measures that include reducing the

¹² <https://www.aap.org/en/news-room/news-releases/aap/2023/american-academy-of-pediatrics-issues-its-first-comprehensive-guideline-on-evaluating-treating-children-and-adolescents-with-obesity/#:~:text=Physicians%20should%20offer%20adolescents%20ages,health%20behavior%20and%20lifestyle%20treatment.>

¹³ https://www.kff.org/policy-watch/medicare-spending-on-ozempic-and-other-glp-1s-is-skyrocketing/?utm_campaign=KFF-Medicare&utm_medium=email&hsenc=p2ANqtz-8kEPirYTRgwglacOILCS3V1DDRIML5TJgT1LDuQBBKidruenLhpzNajdUHX2CYsnJiR74102VRS-Cdixy24f2h_n6w&hsmi=299684398&utm_content=299684398&utm_source=hs_email

¹⁴ <https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-reduce-risk-serious-heart-problems-specifically-adults-obesity-or>

need for prescription drugs while improving measurables for conditions such as high cholesterol, hypertension, and type 2 diabetes? In the fee-for service system, CPT codes that address lifestyle modifications are reimbursed far less than CPT codes for drug prescriptions and surgical procedures. This is despite the fact that lifestyle interventions have been proven to achieve better health outcomes than prescription drugs alone and often require more time and effort from the clinical care team than a prescription drug or surgical procedure might. Behavior change interventions also have far less harmful side effects.

The current quality and payment models also don't reward medication de-escalation as the result of improved health outcomes or even reversed chronic conditions. As an example, in the Medicare Advantage insurance space, a large number of the measures in the Quality Bonus Program are focused on medication adherence as end result and punish plans whose physicians work with patients to improve or reverse their chronic conditions through lifestyle change. Success on these measures is what determines whether plans receive their 5% bonus payment for achieving four or five star status, so we know they "teach to the test", meaning these incentives flow through to their physician contracts.

In the direct physician payment space, for instance, we have payment models where reducing hospitalizations is a quality measure. Why can't we also have quality measures that include reducing the need for prescription drugs while improving measurables for conditions such as high cholesterol, hypertension and type 2 diabetes?

There was some discussion during the hearing, including from Ranking Member Mike Crapo (R-ID), about the role that was envisioned for the Physician-Focused Payment Model Technical Advisory Committee (PTAC) created as part of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 in providing medical specialists an avenue to develop and advance payment models through a rigorous process that would to many of those recommended by the PTAC being implemented by the Center for Medicare and Medicaid Innovation (CMMI). In fact, none of the models recommended were ever implemented and as result the PTAC has withered on the vine. This process needs to be reinvigorated either through a renewed PTAC or some other model the committee creates.

In addition, there are bills already introduced that the committee should advance that would represent some progress in advancing lifestyle medicine solutions to chronic disease. Those include the Medical Nutrition Therapy Act (S. 3297) led by Senators Susan Collins and Gary Peters. This bill expands Medicare coverage of medical nutrition therapy services. Currently, Medicare covers such services for individuals with diabetes or kidney disease under certain circumstances; such services must also be provided by a registered dietitian or nutrition professional pursuant to a physician referral. The bill extends coverage to individuals with other diseases and conditions, including obesity, eating disorders, cancer, and HIV/AIDS; such services may also be referred by a physician assistant, nurse practitioner, clinical nurse specialist, or (for eating disorders) a clinical psychologist. ACLM support passage of the Medically Tailored Meals Act (S. 2133) led by Senators Debbie Stabenow and Roger Marshall, which would create a medically-tailored meals home delivery demonstration program.

Lastly, efforts at long term behavior change and maintenance interventions are often not as effective or efficient when delivered in the traditional, infrequent 1:1 provider-to-patient ratio, 15-minute medical appointment. A best practice for the delivery of lifestyle medicine and support of the necessary behavior change is through shared medical appointments (SMAs) in which patients receive both individual care and group education by a team of clinicians about therapeutic lifestyle changes that can treat or reverse their disease(s). SMAs are not new models, but have been very effective for our members in the delivery of therapeutic lifestyle interventions. SMAs have been shown to help patients learn and support each other in behavior change, increase access to care, achieve better health outcomes and alleviate provider burn-out. However, there are a number of challenges related to the delivery of SMAs for both providers and patients. On the provider side, challenges include compliance concerns related to the number and frequency of E&M visits coded back-to-back as is common in an SMA model, place of service issues for delivering care in community-based settings where patients live and work, challenges in getting approval for the use of modifier 33 to waive patient copays. On the patient side, the number and frequency of SMA programs to address lifestyle-related behaviors can be financially unviable if they require a patient co-pay each visit.

Winston Churchill is believed to have once observed “You can always count on Americans to do the right thing—once they have tried everything else”. We urge the Committee as it considers policies to help “bolster chronic care” to take the steps we have recommended and others to address the root causes of this epidemic. It truly is the right thing and when it comes to chronic disease, we have tried everything else.

For questions related to feedback and recommendations from the American College of Lifestyle Medicine, please contact Kaitlyn Pauly, Deputy Director of Practice Advancement and Administration, at kpauly@lifestylemedicine.org

Regards,

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On behalf of the American College of Physicians (ACP), we appreciate this opportunity to share our recommendations to improve the delivery of chronic care in Medicare. We applaud Chairman Wyden and Ranking Member Crapo for hosting this hearing on Bolstering Chronic Care through the Medicare Physician Fee Schedule (MPFS) and their willingness to consider policies to enhance care for seniors with chronic conditions. We were pleased to work with this Committee several years ago to strengthen chronic care through the passage of S. 870, the Creating High-Quality Results and Outcomes to Improve Chronic (CHRONIC) Care Act and look forward to working with you to ensure that the MPFS provides the support necessary for physicians to provide high quality chronic care for our seniors.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

Although the Chronic Care Act made important changes in improving care for seniors with chronic conditions, additional steps are needed to ensure that our patients have access to high quality chronic care. Six in 10 American adults¹ have at least 1 chronic disease and 4 in 10 have 2 or more, and at \$3.3 trillion in annual health costs, chronic disease is responsible for 75% of aggregate national health care spending and is the largest cause of disability and death.²

General internal medicine physicians assume principal responsibility for coordinating and managing patients’ overall care, particularly for those with multiple complex chronic conditions.³ As the Senate Finance Committee examines policies to bolster chronic care, we urge you to adopt the following measures to ensure lower costs and improve the quality of chronic care in this country:

- Strengthen and Stabilize the MPFS
- Revise Requirements for Budget Neutral Payment Cuts in the MPFS
- Ensure Accurate Estimates of Utilization of New Codes in the MPFS
- Remove Beneficiary Cost Sharing for Chronic Care Management Services
- Support Increased Access to Telehealth Services
- Support the Implementation of Medicare Code G2211
- Expand the Primary Care Physician Workforce
- Support the Elimination of Cost Sharing for Primary Care Services
- Support Increased Payment for Primary Care Physicians

¹ <https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm>.

² <https://www.mdpi.com/1660-4601/15/3/431>.

³ <https://www.acpjournals.org/doi/10.7326/0003-4819-159-9-201311050-00710>.

Strengthen the Medicare Physician Fee Schedule

It is unrealistic to assume that the current MPFS provides the adequate stability and resources necessary for our physicians to deliver high quality chronic care for our patients. Unlike nearly every other segment of the Medicare payment system, the MPFS does not include annual inflationary adjustments. As a result, when accounting for inflation, current Medicare physician payment rates have decreased by a staggering 26% since 2001. The failure of Congress to provide consistent, positive, and stable payment updates is contributing to staffing shortages and service limitations that potentially result in longer wait times or other disruptions impacting patient care.

We urge Congress to approve **H.R. 2474, the Strengthening Medicare for Patients and Providers Act**, which preserves access to care for Medicare beneficiaries by providing an annual inflation update equal to the Medicare Economic Index (MEI) for Medicare physician payment. This legislation is essential to physicians' ability to make needed investments in their practice that help ensure they can continue delivering high quality care to their patients.

Revise Requirements for Implementing Budget Neutral Payment Cuts in the MPFS

In addition to a lack of inflationary updates, each year physician practices face arbitrary payment cuts due to budget neutrality requirements in the annual fee schedule that, unless addressed in a comprehensive way, will continue to plague physicians in the years to come. Although we appreciate that Congress has provided some financial relief to physicians to mitigate the impact of these payment cuts, these measures do not provide the consistency and stability for physicians to meet their expenses and provide high quality care to seniors.

We urge the Finance Committee to approve legislation **H.R. 6545, the Physician Fee Schedule Update and Improvements Act**, which would update the threshold for implementing budget neutral payment cuts in the MPFS. It would raise the budget neutrality threshold to \$53 million and would use cumulative increases in the MEI to update the threshold every 5 years afterwards. We believe that this is a practical approach, which would help account for inflation.

ACP also supports the provisions in the bill that would require CMS to update the direct costs associated with practice expenses (clinical labor, the prices of equipment, and the prices of medical supplies) simultaneously at least once every 5 years.

We also support provisions in this bill that would allocate 3 percent to the 2024 Medicare conversion factor, as well as extend incentive payments for participation in eligible advanced alternative payment models (APMs) through 2026 and would tier bonuses according to how long a physician has participated in an APM, to account for increased upfront costs. The bill includes a provision that would provide the Secretary of Health and Human Services (HHS) with flexibility for tiering bonuses. ACP supports extending incentive payments for APMs to support physicians' transition from a volume-based fee-for-service health care system to one that is based on the value of health care delivered to the patient. Instead of having a tiered approach for bonuses, we recommend that Congress considers freezing the revenue threshold increase for 5 years to encourage more physicians to transition from fee-for service into APMs and maintain financial viability for those already participating in such programs.

Ensure Accurate Calculation of Utilization of New Medicare Payment Codes

ACP is requesting that Congress directs the Government Accountability Office (GAO) to conduct a study and report back to Congress on the utilization estimates and actual payments incurred from the implementation of new Medicare codes by the Centers for Medicare and Medicaid Services (CMS). This language is needed to more accurately determine how much money in Medicare Part B was unnecessarily held back versus the actual amount needed to pay for those services within the first year of implementation. The concern is that money is often withheld from the fee schedule due to budget neutrality and if the estimates are above the actual code utilization, that money doesn't get put back into the fee schedule to fund other service costs. If there is an overestimation in utilization of new codes, it can lead to unnecessary physician payment cuts, which ultimately can hinder patients' access to timely care.

Remove Beneficiary Cost Sharing for Chronic Care Management Services

We remain concerned that many seniors have failed to access chronic care management services due to a patient cost-sharing requirement associated with this care. Current law mandates that Medicare beneficiaries are subject to a 20% coinsurance requirement to receive chronic care management services. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for care management services and may forego the services altogether as a result. The latest data⁴ reveals that only 4% of Medicare beneficiaries potentially eligible for chronic care management received these services. That amounts to 882,000 out of a potential pool of 22.5 million eligible beneficiaries.

We urge you to approve H.R. 2829, the Chronic Care Management Improvement Act of 2023. This legislation would remove the cost sharing requirement for patients to access chronic care management services. We also support allowing the physician that performs chronic care management services to waive the requirement that the patient pay the 20% coinsurance fee associated with this service.

Support Increased Access to Telehealth Services for Medicare Beneficiaries

We support the expanded role of telemedicine as a method of health care delivery that will improve the health of patients with chronic conditions by enabling and enhancing patient-physician collaborations, increasing access to care and members of a patient's health care team, and reducing medical and resource costs when used as a component of a patient's longitudinal care.

Telehealth flexibilities from the pandemic-era public health emergency (PHE) have been instrumental in improving access to care for patients across the U.S. We were pleased that the Consolidated Appropriations Act of 2023 extended many of those flexibilities through the end of 2024.

ACP believes that the following existing flexibilities should be continued—and not allowed to expire—to support making telehealth an ongoing and continued part of medical care now and in the future. We urge the Finance Committee to make these existing flexibilities permanent or to provide long-term extensions for them.

- Expand originating sites and lift geographic requirements for telehealth services
- Allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) to continue to provide telehealth services
- Allow the furnishing of audio-only telehealth services for evaluation and management services

ACP Supports S. 2016/H.R. 4189, the Connect for Health Act of 2023

We urge Congress to approve **S. 2016/H.R. 4189, the Connect for Health Act of 2023.** This legislation would permanently expand access to essential telehealth services including expanding originating sites and lifting geographic requirements for telehealth services and allowing FQHCs and RHCs to continue to provide telehealth services. We urged the Finance Committee to include this legislation in the original CHRONIC Care Act and urge you to act to continue to ensure that seniors have access to these vital telehealth services after they expire at the end of this year.

Ensure Access to Audio-only Telehealth Services

We also support **S. 1636/H.R. 3440, the Protecting Rural Telehealth Access Act**, a bill that would ensure that seniors may continue to access audio-only telehealth consults with their physician after this option expires at the end of this year. ACP strongly supports the use of audio-only telehealth as an effective modality to address gaps in health equity. Primary care and other evaluation and management services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks or have privacy concerns and do not feel comfortable using video visit technology or do not possess the digital literacy to use video technology.

⁴ <https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf>.

Support the Implementation of Medicare Code G2211

We are pleased that at the beginning of this year, CMS implemented Healthcare Common Procedure Coding System (HCPS) add on code G2211 to compensate physicians for the extra work and resource costs required for the coordination of care for complex or serious conditions. This new Medicare code is essential to provide our physicians with the resources necessary to provide high quality care for patients with chronic conditions, and to ensuring that patients have access to a holistic, dynamic, and integrated⁵ system. With implementation, clinicians can now receive payment for services like chronic disease management tracking, review of consultative or diagnostic reports, and medication monitoring that would otherwise be unaccounted for in the current E/M coding structure.

A report by the National Academy of Sciences, Engineering, and Medicine⁶ calls on policymakers to increase the investment in primary care as evidence shows that it is critical for “achieving health care’s quadruple aim: enhancing patient experience, improving population health, reducing costs, and improving the health care team experience.” The report urges reforms to ensure that the Medicare physician payment system no longer undervalues primary and cognitive care, and more adequately incentivizes the type of quality, value-based care that patients need. ACP greatly appreciates the changes by CMS and Congress to help patients and physicians to establish and maintain longitudinal relationships that improve health outcomes. The College looks forward to continuing to work with CMS and Congress to ensure patients have access to continuous and comprehensive care.

Expand the Primary Care Workforce

It is estimated that there will be a shortage of 17,800 to 48,000 primary care physicians by 2034.⁷ As our population ages with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine GME training. It is worth noting that the federal government is the largest explicit provider of GME funding (over \$15 billion annually), with most of the support coming from Medicare.

ACP appreciates Congress’ continued GME expansion with the Consolidated Appropriations Act, (CAA), 2023, H.R. 2617, adding an additional 200 GME slots, 100 for psychiatry and psychiatric subspecialties and 100 for other physician specialties. We urge Congress to continue this momentum through the passage of the **Resident Physician Shortage Reduction Act of 2023, H.R. 2389/S. 1302**, which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for 7 years.

Support the Elimination of Cost Sharing for Primary Care Services

We support waiving beneficiary cost sharing for primary care services. We believe that cost sharing creates barriers to evidence-based, high value, and essential care and should be eliminated, particularly for low-income patients and patients with certain defined chronic illnesses. Evidence⁸ shows that even very low Medicaid copayments are associated with decreased use of necessary care. High deductibles may serve as a barrier to receiving high-value, preventive care and treatment after diagnosis.

Support Sufficient and Sustained Increases in Medicare Payments for Primary Care Services in a Manner that is not Limited by Current Budget Neutrality Constraints

It is essential that Congress develop policies to provide the financial stability needed to help physicians improve the quality and value of care they furnish. As indicated above, a first step would be modifying the current laws that impose arbitrary payment cuts in the MPFS every year. ACP also encourages Congress to develop policies to ensure that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) fulfills its goal as intended to transform Medicare physician payment from a fee-for-service (FFS) model that pays physicians based on the number of services provided to a value-based model that incentivizes the quality and outcome of care delivered to patients. Yet, concern is growing that these programs have fallen far

⁵ https://assets.acponline.org/acp_policy/policies/beyond_the_referral_position_paper_2022.pdf.

⁶ <https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care>.

⁷ <https://www.aamc.org/media/54681/download?attachment>.

⁸ <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

short of truly shifting payments away from a still predominant FFS model or moving the needle toward achieving greater equity in the delivery of health care.

Based on the 2020 ACP paper, *Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms*,⁹ we recommend that all payment systems substantially increase relative and absolute payments for primary care commensurate with its value in achieving better outcomes and lower costs. Inappropriate disparities in payment levels between complex cognitive care and preventive services, relative to procedurally oriented services, should be eliminated. It is essential that payment policies recognize the value of primary care, and that payment is sufficient to reverse the primary care physician shortage. Access to primary care has consistently been associated with higher quality of care,¹⁰ lower mortality rates,¹¹ higher patient satisfaction,¹² and lower total system costs.¹³ Compared with other developed countries, the United States ranked lowest in primary care functions as well as health outcomes, yet highest in health spending.¹⁴ Moreover, studies have shown health outcomes¹⁵ are better in states with higher ratios of primary care physicians¹⁶ within the population than in those with lower ratios. Increasing one primary care physician per 10,000 people in one state was associated with a rise in that state's quality rank by more than 10 places and a reduction in overall spending¹⁷ by \$684 per Medicare beneficiary.

Conclusion

We appreciate the Senate Finance Committee's efforts to bolster chronic care in Medicare and their support for strengthening the MPFS to provide physicians with the resources to provide high-quality care to our seniors. We look forward to working with the Committee to implement these policies as outlined in our statement. Should you have any questions, please do not hesitate to contact Brian Buckley, Senior Associate for Legislative Affairs at bbuckley@acponline.org.

AMERICAN COLLEGE OF RADIOLOGY

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The American College of Radiology (ACR), representing approximately 41,000 radiologists, radiation oncologists, medical physicists, and imaging professionals, appreciates the opportunity to submit a statement for the record in response to the Senate Finance Committee hearing titled "Bolstering Chronic Care Through Medicare Physician Payment" held April 11, 2024.

As a physician medical specialty society, we are acutely aware of the many challenges our members face as they provide high quality care to Medicare beneficiaries. These challenges have been exacerbated by a long-broken Medicare physician payment system, which has failed to keep pace with the true cost of physician practices. According to an American Medical Association analysis of Medicare Trustees data, when adjusted for inflation, physician reimbursement has declined 26 percent from 2001 to 2023. Failure to address this basic underlying reimbursement deficiency threatens the continued ability of physicians to care for their patients.

For many patients, especially those with chronic conditions, teams of physician specialists work in concert with the primary care provider to provide treatments for their patients. This coordinated, teamwork model of care is disincentivized in the Medicare Physician Fee Schedule (MPFS) due to statutorily required budget neutrality.

Additionally, physicians have singularly been excluded in the Medicare system from any kind of annual inflation adjustment that directly impacts the costs of running

⁹ <https://www.acpjournals.org/doi/epdf/10.7326/M19-2407>.

¹⁰ <https://pubmed.ncbi.nlm.nih.gov/16202000/>.

¹¹ <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393>.

¹² <https://pubmed.ncbi.nlm.nih.gov/9752374/>.

¹³ <https://pubmed.ncbi.nlm.nih.gov/22418570/>.

¹⁴ <https://pubmed.ncbi.nlm.nih.gov/11965331/>.

¹⁵ <https://jhu.pure.elsevier.com/en/publications/when-doctors-share-visit-notes-with-patients-a-study-of-patient-a>.

¹⁶ <https://jhu.pure.elsevier.com/en/publications/when-doctors-share-visit-notes-with-patients-a-study-of-patient-a>.

¹⁷ <https://pubmed.ncbi.nlm.nih.gov/15451981/c>.

their practices. Congress must act to add a Medicare Economic Index (MEI) based inflationary update to the MPFS.

With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress intended to encourage and incentivize a transition from traditional fee-for-service to a value-based care model, via either an alternative payment model (APM) or the Merit-based Incentive Payment System (MIPS). Much of diagnostic radiology is non-patient facing, however numerous significant exceptions are found in the provision of breast imaging, and in interventional radiology procedures. As largely non-patient facing physicians, as with a number of other medical specialties, diagnostic radiologists have found it extremely difficult to meaningfully participate in the MACRA statutory programs. Recent studies show that one third to nearly one half of radiologist interactions with Medicare beneficiaries are single, isolated interactions.¹ In addition, outdated and contested CMS regulations prohibit diagnostic radiologists from billing evaluation and management codes,² the codes most frequently billed for patient encounters. These two factors severely limit the ability of radiologists to participate in any value-based payment model. As Congress considers MACRA reform, the nature of practice for all physicians, including radiologists and other non-patient facing physicians, must be considered for true reform to take place.

As a specialty, diagnostic radiology is at the forefront of medical technological innovation and use. The science of radiology is the major component in the diagnosis of most injuries and diseases. If services are provided in a privately owned, non-hospital based practice, the cost and maintenance of the equipment used, the cost of owning or renting space to provide these services, employment of staff and dedicated technologists can only survive like all businesses if there is sufficient reimbursement to cover these expenses. Unfortunately, adequate reimbursement of the practice expense component of the MPFS, which is intended to account for both direct practice expense (clinical labor, supplies, and equipment) and indirect practice expense (rent, administration, and other overhead), falls grievously short of appropriate and necessary reimbursement to allow community based, privately owned practices to survive.

In particular, collecting accurate indirect practice expense data has been challenging due to the complex nature of data sets while having to take into consideration of different specialties' practice patterns. The indirect practice expense data needs to be routinely updated to ensure it is accurate and representative to avoid potentially large swings in reimbursement due to redistributive effects in a budget neutral system.

These reimbursement reductions are felt hardest by smaller, independent practices, like those in rural and underserved areas that continue to face significant health care access challenges. In response, many practices have been acquired by larger healthcare entities, including hospitals, health systems, and corporate healthcare networks, permanently impacting patient access to care. Private practices that have not consolidated are forced to make very difficult decisions when considering investing in technology, potentially hindering innovation and quality of care delivered to patients.

The continued downward spiral of the MPFS and resulting changes in the practice of medicine have contributed to a workforce shortage that is being experienced by the entire physician community, radiology included. Recent data from the American Association of Medical Colleges (AAMC), projects a shortfall of up to 86,000 physicians by 2036. This is extremely concerning, especially considering an ageing population that has benefited from diagnostic imaging technological advances that have enabled patients to live longer with chronic conditions.

Although many patients do not have a face-to-face encounter with their radiologist, radiologists care for more Medicare beneficiaries per year than any other physician, which indicates radiology's prominent role in patient care.³ As a result, the demand for imaging services continues to rise and the supply of radiologists is increasingly

¹ Eric W. Christensen, et al.; Prevalence of "One-Off Events" in Radiology: Implications for Radiology in Episode-Based Alternative Payment Models, <https://www.sciencedirect.com/science/article/abs/pii/S0363018823001238>.

² Medicare Benefit Policy Manual, Ch. 15, §80.6.1, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf>.

³ Andrew B. Rosenkrantz et al.; Unique Medicare Beneficiaries Served: A Radiologist-Focused Specialty-Level Analysis, *Journal of the American College of Radiology*, <https://www.sciencedirect.com/science/article/abs/pii/S1546144018300462>.

unable to meet that demand. One way to reduce the increasing demand for imaging services is to implement Section 218(b) of the Protecting Access to Medicare Act of 2014 (PAMA) which requires all ordering providers to consult appropriate use criteria (AUC) via a clinical decision support mechanism prior to the ordering of advanced diagnostic imaging services for Medicare beneficiaries. This educational tool is critical, particularly in areas where non-physician providers order advanced imaging to both educate the provider and ensure patients receive the right test at the right time. The program can also help eliminate “low value” imaging which can inconvenience the patient, cost both the patient and the Medicare system money and often be of little to no clinical relevance. Although Congress required the PAMA program be implemented by 2017, the Centers for Medicare and Medicaid Services (CMS) has faced significant logistical difficulty during the regulatory process and in the 2024 MPFS final rule indefinitely paused implementation pending statutory changes. CMS also reiterated their support for the program and estimated that if implemented, the PAMA AUC program could save the Medicare system approximately \$700 million annually.

In order to move forward with AUC implementation, the ACR has proposed significant administrative simplification language to the Senate Finance Committee. We urge the swift adoption of the revised, updated legislative text to provide CMS with the statutory changes needed to implement the AUC program. These changes will first and foremost improve patient care by decreasing unnecessary utilization and associated copayment costs and provide a utilization management tool far superior to any prior authorization process. Winnowing down the number of unnecessary advanced imaging studies will also have a direct, dramatic impact on unnecessary imaging studies which will advantage the current status of workforce shortages in diagnostic radiology.

The ACR encourages swift Congressional action to increase both the current and future supply of radiologists. To address current supply, the expansion of the Conrad 30 program (S. 665) would allow more physicians who have trained in the United States on a J-1 visa to continue to practice medicine in the U.S. without having to return to their home country post residency. The Healthcare Workforce Resilience Act (S. 3211) would recapture unused immigrant visas for physicians and nurses, which will ultimately lead to an increase in currently practicing physicians to meet the needs of our population. To address future supply, the ACR encourages passage of the Resident Physician Shortage Reduction Act (S. 1302), and add Medicare funded graduate medical education (GME) slots and help close the projected physician shortfall.

We are encouraged that Congress is recognizing the need for substantive Medicare physician payment reform and look forward to future discussions. If you have any questions, please contact Cindy Moran, Executive Vice President, Government Relations, Economics and Health Policy, at cmoran@acr.org.

Thank you,

Cynthia R. Moran
Executive Vice President

AMERICAN COLLEGE OF SURGEONS

Statement of Firpo Carr, Ph.D., Health Psychologist

As a Health Psychologist who is an Affiliate Member of the American College of Surgeons (ACS), I listened with rapt attention to testimony by a panel of experts appearing before The Senate Finance Committee on April 11, 2024, about “Bolstering Chronic Care through Medicare Physician Payment.” There was an abundance of rich, invaluable information to digest.

Of course, I watched the proceeding through the lens of a psychologist interested in studying surgeons’ mental health and well-being.

However, I surmised that the challenges confronting surgeons and physicians treating chronic care patients and navigating the morphing puzzle pieces of the Medicare Physician Payment system are daunting and inescapably cause significant stress. In this regard, self-care must be emphasized.

Undoubtedly, all had a vested interest in the subject matter. For instance, it was reassuring to witness Senators tincture their observations on chronic care with experiences of family members’ interactions with the medical system. In doing so, they

made themselves relatable to their constituents and sensitive to the American people's general needs.

Accolades aside, there was also reason for pause.

For example, it was concerning to learn from Senator Elizabeth Warren that a particular American Medical Association (AMA) committee has an overrepresentation of specialty physicians who, by sheer numbers, overwhelm primary care physicians (PCP) when voting on payments. Specialists vote to pay themselves considerably more than PCPs. This disparity, which negatively impacts physicians in private practice and their patients, should be addressed.

Moving forward, I was pleased to observe the alertness, acuity, and measured passion of Senators and panelists alike. Self-care should not be underestimated, particularly when politicians and panelists wrestle with the nuts and bolts of effective ways of bolstering chronic care through Medicare physician payment.

Unsurprisingly, I was keenly interested in what ACS Executive Director & CEO Patricia L. Turner, M.D., MBA, FACS, had to say and was pleased to see her emphasize how the ACS is a pacesetter for high-quality, evidence-based surgical care as substantiated by its 13 quality programs.

Additionally, I especially appreciated that, along with Dr. Turner's insightful expert testimony, she showed deference to the profound thoughts of her fellow expert panelists—each representing their respective organizations—stating that all the boats in the harbor can rise together.

The main takeaway for me was that, while there is still plenty of work to be done, the perseverance of the Senate Finance Committee should be applauded. The endurance and stick-to-itiveness of panelists representing their colleagues should be celebrated.

To be sure, the issues are formidable and can only be dealt with through a concerted effort. All will do well to be mindful that the first step to resolution is self-care as reflected in the maxim expressed in Latin, *Medice, cura te ipsum*, that is, "Physician, heal thyself" (Luke 4:23).

Humble thanks to Senator Ron Wyden and the rest of the Senate Finance Committee, as well as to all the esteemed panelists.

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Statement of Lisa Murdock, Chief Advocacy Officer

Thank you, Chairman Wyden, Ranking Member Crapo, and distinguished members of the Finance Committee, for providing the American Diabetes Association (ADA) the opportunity to submit written comments regarding the impact of Medicare physician reimbursement policy on care for Americans with diabetes and other chronic conditions. We appreciate you considering this important topic at this critical time.

The ADA is the nation's leading voluntary health organization fighting to bend the curve on the diabetes epidemic and help people living with diabetes thrive. For more than 80 years, the ADA has been driving discovery and research to treat, manage and prevent diabetes, while working relentlessly for a cure. We help people with diabetes thrive by fighting for their rights and developing programs, advocacy and education designed to improve their quality of life.

Access to care for the 38.4 million Americans with diabetes is critical to effective management of this condition and to preventing unnecessary, dangerous and often life-threatening complications. That access is at risk as our country faces shortages of physicians—and in particular endocrinologists and primary care doctors—who are crucial to the treatment of diabetes.

Adequate Medicare reimbursement across physician specialties is a necessary step toward addressing this country's shortage of physicians and other health workers. Since the beginning of the COVID-19 pandemic, nearly one in five health care workers has resigned, and surveys suggest that nearly 50 percent of the U.S. health

care workforce has considered or is considering leaving within the next 2 years.¹ This situation is dire for people with diabetes, who outnumber practicing endocrinologists by a ratio of 40,000 to 1.² Partly as a result, the diabetes community relies overwhelmingly on primary care providers—who care for some 90 percent of people with Type 2 diabetes, the fastest-growing subset of the diabetes population—to oversee their insulin regimens, provide diabetes education, and prescribe continuous glucose monitors and other diabetes management tools. Nearly 70 percent of outpatient visits for all adults with diabetes take place in primary care settings, and 76 percent of visits are scheduled specifically due to diabetes.³ The post-pandemic “great resignation” is having an impact here too. In 2021 and 2022, this wave of clinician resignations already included 145,213 physicians and 34,834 nurse practitioners, coming predominantly from internal medicine and family practice.⁴

To improve the stability of primary care practitioners, the federal government should increase Medicare reimbursement rates and especially focus payments on expanding under-resourced primary care teams. Team-based care is a critical part of the answer to the problems of physician shortage and increased workload. Research shows that nurse practitioners, physician assistants and other advanced care providers, in addition to pharmacists and community health workers, help patients reduce A1C, begin and adjust medications without physician approval, and generally improve clinical outcomes for patients with type 2 diabetes in primary care settings.

This approach does not require Medicare to reinvent the wheel. Congress and the administration can encourage team-based care delivery in primary care practices by increasing reimbursement rates through existing federal health care programs for providers and their community partners. The Centers for Medicare and Medicaid Services (CMS) is already doing some of this important work. CMS proposed changes to its Physician Fee Schedule for calendar years 2023 and 2024 to increase reimbursement rates for primary care clinicians and chronic care management services and pay for services provided by “auxiliary personnel” such as community health workers. CMS has also launched a series of demonstration projects that use prospective-based payments to incentivize advanced primary care delivery. Its recently announced project—the ACO Primary Care Flex Model—will test whether and how these payment models can improve outcomes and reduce costs in the Medicare Shared Savings Program, especially for those Medicare beneficiaries living in medically underserved communities. Congress and the patient community stand to learn a great deal from the outcome of this primary care payment model in particular, as the findings from ACO Primary Care Flex can inform how Medicare reimbursement affects outcomes for patients living with chronic conditions.

Medicare can also reduce expensive complications from diabetes by using reimbursement policy to encourage more preventive care services. ADA recently launched the Amputation Prevention Alliance to spread awareness about preventive interventions, including those that can be performed in a primary care office, to limit diabetes-related amputations. Eighty-five percent of diabetes-related amputations are preventable, and amputees with diabetes experience a significantly elevated risk of mortality following the loss of a limb—one in 10 dies within 30 days of surgery, and one in six dies within 90 days.⁵ Minimally invasive procedures to diagnose cases of peripheral artery disease (PAD) and critical limb ischemia (CLI) are generally not covered by federal health care programs like Medicare. The ADA urges Medicare to cover PAD screening for at-risk beneficiaries without cost-sharing requirements.

Congress may also consider a value-based payment model in which reimbursement rates for primary care providers are adjusted based on access to diabetic foot ulcer and PAD assessments and patient-reported outcome metrics (*e.g.*, wound healing time, wound free time, wound recurrence rates and low to high amputation ratios).

¹ Ethan Popowitz, “Addressing the Healthcare Staffing Shortage,” *Definitive Healthcare*, September 2023, https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the-healthcare-staffing-shortage-2023.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top.

² “Number of People per Active Physician by Specialty, 2021.”

³ Scott J. Pilla, MD, MHS, Jodi B. Segal, MD, MPH, and Nisa M. Maruthur, MD, MHS, “Primary Care Provides the Majority of Outpatient Care for Patients with Diabetes in the US,” *Journal of General Internal Medicine*, July 2019, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6614213/#:~:text=Among%20non%2Dhospital%2Dbased%20office,a%20patient%20reason%20for%20visit>.

⁴ Popowitz, “Addressing the Healthcare Staffing Shortage.”

⁵ Jason K. Gurney, James Stanley, Juliet Rumball-Smith, Steve York, “Postoperative Death After Lower-Limb Amputation in a National Prevalent Cohort of Patients with Diabetes,” *Diabetes Care*, April 5, 2018, <https://care.diabetesjournals.org/content/41/6/1204>.

Ultimately, achievable Medicare reimbursement reforms that prioritize all members of the primary care team and focus on chronic care management and preventive care can improve patient outcomes and significantly reduce long-term costs to the U.S. health care system.

Thank you for the opportunity to submit this testimony for the record. The ADA looks forward to continuing to work with Congress to make sure our community has access to the health care providers and resources they need to effectively manage their diabetes.

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The American Geriatrics Society (AGS) greatly appreciates the opportunity to provide feedback to the Senate Committee on Finance as it begins its efforts to develop legislation to reform the Physician Fee Schedule and update MACRA.

The mission of the AGS, a nationwide not-for-profit organization comprised of nearly 6,000 geriatrics clinicians is to improve the health, independence, and quality of life of all older adults. Our members are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. AGS believes in a just society, one where we all are supported by and able to contribute to communities where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. AGS believes increased payment accuracy for clinicians paid under the Physician Fee Schedule and through the Quality Payment Program (QPP), established by the Medicare Access and CHIP Reauthorization Act (MACRA) is a cornerstone to improving access to care in rural and historically minoritized communities. AGS is actively engaged in efforts to advance value-based, high-quality care for older Americans, and we appreciate the committee's willingness to listen to our concerns and experience with these programs.

MACRA replaced the unworkable cost control mechanism of the Sustainable Growth Rate (SGR) with a new payment system intended to incentivize value-based care. However, MACRA—particularly the provisions establishing the Merit-based Incentive Payment System (MIPS)—uses an “accountability” mechanism that is largely siloed by individual disease states and conditions, focuses disproportionately on performance and payment at the individual clinician and individual specialty level, and, as a result of its budget neutrality requirements, picks clinician “winners” and “losers.” We cannot achieve the promise of value-based care with this fragmented approach, which is organized around organ-specific care and does not take a whole person approach to health and well-being. In our view, a high-quality, cost-effective healthcare system results from care that is person-centered, team-based and grounded in strong primary care—the payment system must reflect, reinforce, and incentivize this type of care.

Specifically, the AGS believes that truly value-based care requires:

- Multi-disciplinary teams of physicians and non-physician practitioners caring for patients, with the primary care practitioner central to facilitating care coordination.
- Strong primary care, as envisioned in the report of the National Academies of Sciences, Engineering and Medicine: “Implementing High Quality Primary Care,”¹ with meaningful education for beneficiaries on the importance of every person having an established source of primary care.
- A whole-person orientation with input from patients and their families, where areas of quality measurement focus on patient goals and experiences, person-oriented outcomes, and the total cost of care for that patient rather than on condition- or specialty-specific outcomes as a metric for higher reimbursement.
- An intentional commitment to equitable care and reducing disparities by, among other strategies, financially supporting organizations embedded in un-

¹National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. doi: 10.17226/25983.

derserved communities, including rural and urban Health Professional Shortage Areas, and providing financial incentives for care management services, particularly to historically minoritized and rural communities (*e.g.*, support for self-care or navigating complex health systems). Importantly, the payment system must not financially “punish” those who care for communities with less advantage or people with greater complexity.

- A regulatory, payment, and technological framework that permits providers flexibility to establish practice organizations that are best for the people they care for and that reduces the financial, legal, and regulatory burdens that have led to the rapid consolidation and monetization of healthcare in the United States. Nearly three-quarters of U.S. doctors work for corporate entities such as private equity firms, health insurers and hospitals in 2022, up from 69 percent in 2021.² Rather than driving system efficiencies and savings, studies show that private equity acquisitions of physician practices are associated with increased healthcare spending and patient utilization, with the average charge per claim increasing 20 percent and the average allowed amount per claim up 11 percent post-acquisition.³
- Accessible care settings for people, including care that is accessible to patients in their homes through telemedicine and programs such as “hospital at home” and “Independence at Home,” when clinicians deem it appropriate based on shared decision-making with their patients.
- Administrative expertise and analytic support for clinical teams, with an overall goal of reducing administrative burden, so that clinicians can both maintain focus on care and still have ownership and involvement in quality measurement (and prevent unnecessary consolidation of physician practices).
- Electronic health information exchanges and electronic health records (“EHR”) systems that are helpful, not a hassle, and that easily permit patient information to be shared across different entities that care for the patient to support clinical decision-making and care coordination and mitigate patient risk and waste (including through use of data-driven tools that take advantage of artificial intelligence technologies).
- Both stability and flexibility whereby investments in value-based care transformation can be confidently made, but with enough flexibility to correct for the inevitable miscalculations and missteps inherent in any change.
- Greater diversity in the health care professions through more reasonable cost of education and greater consideration of programs like the National Health Services Corps.
- Payments that include:
 - Incentives that are generally positive, with limited negative incentives for maintaining the fee-for-service status quo.
 - Reasonable payment updates that reflect changes in the cost of providing care as well as inflation. Adjusted for inflation in medical practice costs, as measured by the Medicare Economic Index (MEI), Medicare physician payment rates declined 20 percent from 2001 to 2021.

The AGS believes that these are attainable goals and ones that must be reflected in any legislative effort that considers the future of physician payment. It is also critical that Congress recognize that the long-term vision of developing a better performing health care system at times may be in tension with saving Medicare dollars in the short run. Congress should not preoccupy itself with short-term savings to the detriment of long-term goals. As with any system seeking transformation, we must be willing to make upfront investments in order to achieve long-term efficiencies and quality improvements.

With these goals in mind, we recommend that the Committee take a holistic approach to reviewing physician payment under Medicare. At a minimum, **Congress must establish a stable, annual Medicare physician payment update that keeps pace with inflation and practice costs and allows for innovation to ensure Medicare patients continue to have access to multi-disciplinary team-based care across specialties.**

²Physicians Advocacy Institute, COVID-19’s Impact on Acquisitions of Physician Practices and Physician Employment 2019–2021, a study prepared by Avalere Health, April 2022, http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZ/I mFdXlvGg%3d%3d.

³Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. *JAMA Health Forum*. 2022;3(9):e222886. doi:10.1001/jamahealthforum.2022.2886.

Our recommendations for steps that Congress could take that stabilize the payment system include:

1. Foster performance-based care that values and supports geriatrics care teams for complex and high-cost patients.

The Center for Medicare and Medicaid Innovation has comprehensive primary care programs. These programs allow the physician practice to increase capacity and skill sets by providing a monthly fee that is designed to allow practices to bring in nurse care managers, pharmacists, integrated behavioral health, staff to support assistance in patients with disadvantaged social determinants of health, for example. This promotes more effective panel management and greater access to primary care. It allows practices to be ready to assume the obligations of accountable care payment programs. They also promote partial capitation for primary care services, so practices are not just focused on visit volumes. These programs should be rapidly expanded for practices that wish to enroll in them. They implement the National Academies of Sciences, Engineering, and Medicine⁴ recommendations to strengthen interprofessional teams and ensure that care teams reflect the diversity of the communities they serve. However, expansion will require infrastructure support, funding, and attitudinal shift.

Comprehensive Primary Care Plus (“CPC+”) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. This program not only strengthens primary care for all beneficiaries but is also designed to meet the specific needs of the chronically ill patient. Currently, participation is limited to certain geographic regions and not all practices that hoped to participate were selected.

Beyond CPC+, there are many successful models and innovations that help achieve the goal state for primary health care. We urge the Committee to review “Complexities of Care: Common Components of Models of Care in Geriatrics” (2022)⁵ as well as the models listed in the NASEM’s report, “Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021).”⁶ Complexities of Care, published in the *Journal of the American Geriatrics Society* explored the common components of models of care in geriatrics when caring for older adults with “care complexity.” The article defines care complexity in older adults, reviews healthcare models and the most common components within them and identifies potential gaps that require attention to reduce the burden of care complexity in older adults. While these models show great promise, most are, unfortunately, limited in scope and not universally available.

2. Reinstate the Primary Care Bonus Payment

As part of the Affordable Care Act (ACA), Medicare implemented a 10 percent bonus payment for primary care physicians for 5 years. The bonus payment expired at the end of 2015. The AGS urges Congress to consider restoring the payment indefinitely, which would help create a more stable environment and provide an incentive for new physicians, advanced practice nurses, and physician assistants to enter and stay in primary care, including geriatrics. The current shortage is the result of under-funding of primary care, which has made careers in primary care medicine unattractive to graduating physicians because of the relatively low incomes they generate compared to other medical fields. Primary care also has greater levels of responsibility between visits, in quality reporting, and in dealing with the shortcomings of electronic health records (EHRs).

3. Expand Telehealth

Medicare beneficiaries need permanent access to telehealth and practices need adequate payment for it. We have learned telehealth can improve safety and access for Medicare beneficiaries when they receive healthcare services. We also have experienced the need to cover audio only services due to issues with patients’ technology management challenges and broadband access. These

⁴National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

⁵<https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.17811>.

⁶<https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care>.

services can effectively substitute for in person visits⁷ and create access for those that previously lacked the ability to get medical and behavioral health-care needs met. Payment must be adequate for these services. These services require the use of clinical staff and indirect practice expenses. Insufficient payment undermines a practice's ability to provide the services.

4. *Revamp Quality Measurement*

AGS strongly encourages the development and deployment of quality metrics related to patient goals and treatment burden. Medicare should create and adopt a more holistic approach to quality measurement in older adults with multiple chronic conditions that does not rely on single disease payments. Elements of such a system could be modeled upon the 4Ms of age-friendly care with an emphasis on what matters to the person.⁸

Thank you for your leadership and commitment to reforming MACRA to stabilize physician practices and strengthen primary care, particularly for older adults living with chronic conditions and/or functional limitations. The AGS believes that traditional Medicare must remain a strong, viable option to help balance market forces in Medicare Advantage and preserve beneficiary choice and access. It is crucial that reforms to MACRA ensure that we have a robust primary care workforce that is equipped and able to deliver the person-centered care that Medicare beneficiaries deserve; that is, assuring the primacy of individuals' health and life goals in their care planning and in the care they receive. The AGS looks forward to working collaboratively with you to achieve these goals as you develop legislative solutions.

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The American Medical Association (AMA) appreciates the opportunity to submit this Statement for the Record for the U.S. Senate Finance Committee hearing entitled "Bolstering Chronic Care through Medicare Physician Payment." This hearing signifies a critical step forward in the ongoing endeavor to modernize traditional Medicare, focusing on the management and treatment of chronic illnesses and the payment structures for physicians and other health professionals. The AMA commends the Committee for its dedication to enhancing Medicare's support for individuals with chronic conditions, such as cancer, diabetes, and heart disease. This commitment was exemplified by the passage of the CHRONIC Care Act in 2018, which instituted comprehensive policy improvements to better meet the complex health care needs of seniors. The AMA is fully supportive of these efforts to update and strengthen Medicare and looks forward to collaborating with the Committee to aid in shaping policies ensuring high-quality, sustainable care for future generations.

CHRONIC CARE MANAGEMENT IMPROVEMENT ACT OF 2023

The AMA supports H.R. 2829, the Chronic Care Management Improvement Act of 2023, which is a critical avenue for enhancing chronic disease management within the Medicare program. This legislation, aimed at eliminating patient cost-sharing for Chronic Care Management (CCM) services, addresses a significant barrier that has hindered the widespread adoption of these essential services. Despite the demonstrated benefits of CCM in improving patient outcomes and reducing hospitalizations, the latest data points to a stark underutilization, with only 4 percent of eligible Medicare beneficiaries receiving CCM services representing only 882,000 out of an estimated 22.5 million.

In addition to the legislative removal of cost-sharing obligations, a concerted effort by the Centers for Medicare & Medicaid Services (CMS) to partner with states could further increase access to CCM services. This could be achieved through the inclusion of CCM services in state Medicaid plans. Such measures would not only amplify the reach of CCM but also enhance patient engagement in self-management of their health conditions to prevent exacerbations, particularly for those managing chronic diseases.

⁷ Cuellar A, Pomeroy JML, Burla S, Jena AB. Outpatient Care Among Users and Nonusers of Direct-to-Patient Telehealth: Observational Study. *J Med Internet Res*. 2022 Jun 6;24(6):e37574. doi: 10.2196/37574. PMID: 35666556; PMCID: PMC9210206.

⁸ Institute for Healthcare Improvement. "Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults" (2020). https://www.american geriatrics.org/sites/default/files/inline-files/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf.

Waiving patient cost-sharing for CCM services is an important step towards removing obstacles to care management services, including patient-initiated navigation (PIN), and ensuring that Medicare beneficiaries receive the comprehensive care coordination they require. This legislative action, coupled with enhanced CMS and state collaboration, can improve the use of CCM services and health outcomes for millions of Americans living with chronic conditions.

AMA'S COMMITMENT TO PREVENTING AND TREATING CHRONIC DISEASE

Chronic disease is a leading cause of death and disability in the United States (U.S.). According to the Centers for Disease Control and Prevention (CDC), each year more than 877,500 Americans die of heart disease or stroke, more than 1.7 million people are diagnosed with cancer, and more than 37.3 million Americans have diabetes, with an additional 98 million adults diagnosed with prediabetes, which puts them at risk for type 2 diabetes.¹ CDC estimates indicate that these diseases, along with other conditions such as obesity, Alzheimer's, and mental health issues, place a significant burden on the economy, accounting for 90 percent of our nation's \$4.1 trillion in annual health care spending. These figures will undoubtedly worsen as the population ages.²

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for one in four deaths among adults. Two major risk factors for CVD are hypertension and type 2 diabetes. CVD risk factors and associated morbidity and mortality inequitably impact Black, Hispanic/Latinx, Indigenous, Asian/Pacific Islanders, and other people of color. While specific causes of the inequities vary by each respective group, structural and societal barriers are attributed as primary reasons.

To prevent CVD and address related health inequities, the AMA is developing and disseminating CVD prevention solutions in collaboration with health care and public health leaders. These solutions educate clinical care teams and patients, guide health care organizations (HCOs) in clinical quality improvement and promote policy changes to remove barriers to care. The AMA disseminates these solutions through strategic alliances with various organizations, including the CDC, the American Heart Association (AHA), and West Side United in Chicago. Another CVD risk is obesity which is associated with cardiovascular disease mortality independent of other cardiovascular risk factors. The AMA is working with other medical societies, including the American College of Physicians and the Obesity Medicine Association, to identify opportunities to improve access to evidence-based obesity treatments. The AMA supports S. 2407/H.R. 4818, the Treat and Reduce Obesity Act, which would provide Medicare beneficiaries with access to safe, effective, and life-saving treatments. The bill aims to effectively treat and reduce obesity in older Americans by enhancing Medicare beneficiaries' access to health care professionals who are best suited to provide intensive behavioral therapy and by allowing Medicare Part D to cover Food & Drug Administration (FDA)-approved anti-obesity medications.

PREVENTIVE HEALTH SAVINGS ACT

Allowing Congress the ability to look at the financial impact of preventive health legislation beyond the 10-year CBO scoring window is another important tool that is critical for addressing chronic conditions in this country. Consequently, the AMA has endorsed³ S. 114/H.R. 766, originally named as the Preventive Health Savings Act, and renamed in the House of Representatives as the "Dr. Michael C. Burgess Preventive Health Savings Act." Congress should be able to consider the long-term economic benefits of legislation that promotes wellness and disease prevention and reduces the incidence of chronic conditions, yet it is constrained from doing so by the 10-year CBO scoring window. This legislation will importantly provide the Chair and Ranking Member of either budget or health-related committees in the House and Senate with the ability to request an analysis of the two 10-year periods beyond the existing initial 10-year window. Furthermore, the legislation's definition of "preventive health" appropriately captures the unique nature of this concept by including actions that focus on the health of the public, individuals, and defined popu-

¹<https://www.cdc.gov/chronicdisease/about/costs/index.htm>.

²*Id.*

³<https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Fstructured%2Fbinary%2Fletter%2FLETTERS%2Flets.zip%2F2024-2-5-Letter-to-Chair-Arrington-and-Ranking-Member-Boyle-re-HR-766-Preventive-Health-Savings-Act-118th-Congress-v3.pdf>.

lations to protect, promote, and maintain health and wellness, as well as prevent disease, disability, and premature death as demonstrated in credible, publicly available studies and data. It is widely recognized that preventing a chronic condition will improve health outcomes, reduce costs to our health care system and provide patients with a better quality of life. It is well past time for the CBO to have a scoring methodology that accurately accounts for these long-term economic benefits.

PREVENT DIABETES ACT

The CDC's National Diabetes Prevention Program (DPP), which has the objective of decreasing the incidence of patients developing Type 2 diabetes by incorporating behavioral counseling, exercise, and nutrition counseling, is a proven program that has demonstrated a decrease in the incidence of patients with pre-diabetes, thereby reducing the incidence of Type 2 diabetes. This successful program was the first pilot approved by the Centers for Medicare and Medicaid Innovation (CMMI) for expanded Medicare coverage and is known as the Medicare Diabetes Prevention Program (MDPP). The limitations Medicare has placed on the MDPP have reduced uptake of these important diabetes prevention services and thereby limited the success of the program in preventing the incidence of Medicare beneficiaries with pre-diabetes. As of the end of 2022, cumulative MDPP enrollment stood at 4,848 Medicare beneficiaries, which is striking considering more than half a million individuals participate in the CDC's National DPP program when offered through their health plan or employer. Many Congressional districts lack in-person MDPP locations to serve the tens of thousands of at-risk constituents otherwise eligible for these services under Medicare. Almost one in three adults aged 65 and older have diabetes. According to CMS, medical care for seniors with diabetes and its complications cost the U.S. \$205 billion in 2022, most of it paid by Medicare. According to the CDC, some 98 million Americans have prediabetes, including 27.2 million who are aged 65 and older. Without a significant course correction, those numbers will only grow. Consequently, the AMA has endorsed H.R. 7856, the PREVENT DIABETES Act. This legislation, which would broaden access to diabetes prevention services by aligning the MDPP with the CDC's DPP, make MDPP a permanent benefit in Medicare, ensure seniors can participate in the program more than once, and expand access to all CDC-recognized delivery modalities, including virtual diabetes prevention platforms in the program, will help ensure that the full potential of this program to reduce the incidence of Medicare beneficiaries with pre-diabetes, and prevent Type 2 diabetes, is realized.

PRESERVING PATIENT ACCESS TO CARE THROUGH PHYSICIAN FINANCIAL STABILITY

Need for an Inflation-Based Update to Physician Payment

For services provided to Medicare beneficiaries in the first 2 months of the year, physicians' payments were cut 3.37 under current law. We appreciate Congress for acting to partially mitigate that reduction, however as of March 9th, physicians are still experiencing a Medicare cut of nearly 2 percent. At the same time, the cost of practicing medicine is rising at the fastest rate in decades, as CMS estimated the cost to run a medical practice increased by 4.6 percent in 2024. An inflation-based update to physician payment is critical to change the unsustainable trajectory of the current payment system, which not only jeopardizes patients' access to physician services but also poses significant challenges in managing chronic conditions effectively. The consequences of the continued real-dollar cuts to Medicare payments, exacerbated by the absence of statutory updates aligned with the inflation in medical practice costs and the problems with Medicare's budget neutrality rules has resulted in a 29 percent decline in physician payments adjusted for inflation in medical practice costs since 2001.

Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. In multiple annual reports, the Medicare Trustees have stated that they "expect access to Medicare-participating physicians to become a significant issue in the long term" unless Congress takes steps to bolster the system. The Trustees noted in 2023, for example, that "the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases." The current Medicare physician payment system—with its lack of an adequate annual update—is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries.

Hospitals, skilled nursing facilities, and nearly every other Medicare provider receive an automatic annual update tied to inflation. Physicians compete in the same marketplaces as these providers for clinical and administrative staff, equipment, and supplies. Yet physicians are at a significant disadvantage due to payment cuts and because their payments have failed to keep up with inflation. Furthermore, hospitals have multiple sources of relief during times of high inflation, including the 340B program and Disproportionate Share Hospital (SDH) payments to account for uncompensated care. It is no wonder that these trends are driving consolidation, which is highly likely to increase future Medicare costs as these other providers receive increasingly higher payments than the diminishing number of independent medical practices. A recent AMA analysis⁴ shows that by far, the most cited reason that independent physicians sell their practices to hospitals or health systems had to do with inadequate payment. Next were the need to better manage payers' regulatory and administrative requirements and the need to improve access to costly resources. The AMA strongly supports policies that promote market competition and patient choice. Payment adequacy is necessary for physicians to continue to have the ability to practice independently.

In its recent March Report⁵ to Congress, the Medicare Payment Advisory Commission (MedPAC) called for a physician payment update tied to the Medicare Economic Index (MEI) in 2025, following a similar recommendation⁶ for increasing physician payment in 2024. Unlike the temporary patches that Congress has adopted in recent years, MedPAC calls for permanent updates to physician payment that would be built into subsequent years' payment rates. While the AMA has commended the Commission for taking this significant step, we note that implementing an inflation-based update based on only half of the full MEI growth rate, as recommended, would be a missed opportunity to meaningfully address the perennial issue of Medicare physician underpayment that threatens stable access to care for millions of Medicare beneficiaries.

We continue to believe that MedPAC's rationale that half of MEI is sufficient because the practice expense component of physician payment accounts for approximately half of total Medicare physician payments reflects an incomplete picture of the cost of running a medical practice. It is well understood that the practice expense component does not cover all practice costs. For example, in the 2024 Medicare Physician Payment Schedule (MPS) final rule, the Centers for Medicare & Medicaid Services (CMS) applies a direct cost scaling adjustment of 0.4637. In other words, for a supply that costs \$100, CMS will include \$46.37 or a reduction of \$53.63 from the invoice cost of the item in the direct expense allocation for the service. Additionally, practice expense is only one component of a multifactorial formula to compensate physicians for the total costs of running a medical practice and caring for Medicare beneficiaries. Payment for physician work—the time, energy, and expertise devoted to treating patients by physicians, nurse practitioners, physician assistants and other qualified health care professionals—is no less important, also contributes to total cost in the provision of a service and is equally impacted by inflation. Therefore, an inflation-based payment update is equally warranted for physician work and other aspects of total physician payment, all of which could be addressed by finalizing an update that is tied to full, rather than half, of MEI.

We appreciate that Congress passed legislation that, again, mitigated severe Medicare payment cuts. However, these temporary, partial patches are a distraction, exacerbate budgeting challenges for practices, and divert resources that both medicine and Congress could be spending on other meaningful health care policies and innovations. Therefore, organized medicine is united in support of a long-term payment solution that centers on annual inflationary updates. **Specifically, we ask Congress to pass H.R. 2474, the “Strengthening Medicare for Patients and Providers Act,” which provides a permanent annual update equal to the increase in the MEI.** Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient centered care and enable CMS to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care.

⁴<https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf>.

⁵https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

⁶https://www.medpac.gov/wp-content/uploads/2023/03/Ch4_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

Improvements to Budget Neutrality

Another way to help ensure physicians have ample resources to provide more care in the home is via reforms to statutory budget neutrality requirements within the Medicare Physician Fee Schedule. The AMA urges the Senate Finance Committee to introduce companion legislation to H.R. 6371, the Provider Reimbursement Stability Act. The House Energy and Commerce Committee has taken action on a portion of this legislation when it passed H.R. 6545, the Physician Fee Schedule Update and Improvement Act, out of committee in December 2023. The reality is that physician payments are further eroded by frequent and large payment redistributions caused by these budget neutrality adjustments. CMS actuaries have on occasion overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule. When these misestimates are not adjusted in a timely way, it results in permanent removal of billions of dollars from the payment pool. Given the statutory authority for budget neutrality adjustments to be made “to the extent the Secretary determines to be necessary,” current law allows CMS to account for past overestimates of spending when applying budget neutrality. Congress should consider requiring a look-back period (as have been implemented in other payment systems) that would allow the Agency to correct for misestimates and adjust the conversion factor to reflect actual claims data. In addition, the \$20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was established in 1989—3 years before the current physician payment system took effect. There have been no adjustments for inflation. As a result, the amount should be increased to \$53 million to best account for past inflation. Further, Congress should limit the year-to-year variance in the Physician Fee Schedule conversion factor due to budget neutrality to a no greater than 2.5 percent increase or decrease. This would help to add more stability and predictability to the physician payment system.

Reduce Burdens in Merit-based Incentive Payment System (MIPS) and Provide Access to Key Data

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AMA has worked closely with Congress and CMS to promote a smooth implementation of MIPS. We supported MACRA’s goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System, and Value-Based Payment Modifier programs. However, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, which was drastically disrupted by the COVID-19 pandemic and the Change Healthcare cyberattack. Further refinements are urgently needed to achieve the goals of MACRA and reduce the administrative burden for physicians. Worse, there is a growing body of evidence that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients.

While CMS has tried to improve the program, such as by introducing the MIPS Value Pathways (MVPs) option, these changes are superficial as the agency believes it does not have statutory authority to remedy these problems directly. Congress must step in and act to prevent unsustainable penalties, particularly on small, rural, and underserved practices; ensure access to timely data; reduce unnecessary burdens; and increase clinical relevance to physicians and their patients. Specifically, we recommend the following legislative changes:

1. Mitigate steep MIPS penalties following the COVID-19 pandemic and Change Healthcare cyberattack that disrupted MIPS implementation and prevent financial disaster for small, rural, and underserved practices.
2. Hold CMS accountable for timely and actionable MIPS and claims data.
3. Enhance measurement accuracy and validity, align cost and quality performance, and promote clinical data registries and other promising technology to making MIPS more clinically relevant while reducing burden.

We urge Congress to consider these recommendations and look forward to collaborating closely on these critical issues to ensure that health care providers, especially those in rural and underserved areas, are supported effectively through the MIPS framework.

Alternative Payment Models

Value-based alternative payment models (APMs) have a successful track record of improving health outcomes and reducing costs. The AMA supports S. 3503/ H.R. 5013, the Value in Health Care (VALUE) Act, introduced by Senators Whitehouse (D-RI) and Barrasso (R-WY.) in the Senate and Representatives Darin LaHood (R-IL) and Suzan DelBene (D-WA) in the House that would extend the 5 percent APM bonus and maintain the 50 percent revenue threshold for 2 years.

This bipartisan legislation would help ensure that physicians in communities across the country have meaningful incentives to participate in alternative payment models that will deliver high quality, coordinated health care for patients. APMs have played a key role in providing high-quality care for Medicare beneficiaries while producing billions of dollars in savings for taxpayers over the past decade.

The AMA urges Congress to build on the success of current APMs by finding additional pathways to help develop a more robust pipeline of APMS available to all types of physicians in all geographic locations in the country.

ELIMINATING EFT FEES TO STREAMLINE HEALTH CARE PAYMENTS

The AMA urges the Committee to consider the passage of the “No Fees for EFTs Act” as a crucial step towards enhancing the efficiency and effectiveness of chronic care management across the U.S. By addressing this legislative issue, the Committee would not only be supporting the financial sustainability of health care practices but also contributing to the broader goal of improving care for patients with chronic conditions.

The burden of electronic funds transfer (EFT) fees, as outlined in our support for H.R. 6487, the “No Fees for EFTs Act” in the House, and support for S. 3805, the corresponding Senate bill, highlights a significant barrier to the efficient operation of health care practices. EFT fees, often amounting to 2 to 5 percent of the claim payment, are levied by certain health plans and their intermediaries without a clear agreement from health care practices. This not only exacerbates the financial strain on these practices but also diverts valuable resources away from patient care and resources that are crucial for the management of chronic illnesses. In addition, for health care providers in rural and underserved areas, where chronic conditions are prevalent and resources are scarce, the impact of these fees is even more pronounced. These areas frequently face challenges in accessing comprehensive care, and administrative inefficiencies only serve to exacerbate these disparities.

By eliminating EFT fees, the “No Fees for EFTs Act” would significantly reduce administrative complexities, freeing up resources that could be better allocated toward patient care. This is especially important in chronic care management, where continuous, comprehensive care is necessary for managing long-term health conditions. The reduction of administrative burdens would allow health care providers to invest more time caring for patients.

TELEHEALTH ACCESS THROUGH LEGISLATIVE REFORM

The AMA supports the role of telehealth in managing chronic illnesses and advocates for the permanent removal of restrictions limiting Medicare patients’ access to these services. Through legislative proposals such as the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2016/H.R. 4189) and the Telehealth Modernization Act (S. 3967/H.R. 7623), there is a pathway for permanency of the advances made in telehealth accessibility, particularly vital for patients managing chronic conditions.

Introduced by Senators Schatz (D–HI) and Wicker (R–MS), the CONNECT for Health Act is bipartisan legislation that would permanently extend many important COVID–19 telehealth flexibilities that have significantly improved access to care for patients in rural and underserved areas. More specifically, the bill repeals the existing Medicare geographic site restrictions and permanently modifies the originating site requirements to allow patients to receive telehealth services wherever the patient can access a telecommunications system, including, but not limited, to the home. These COVID–19 policies have allowed patients to obtain telehealth services at home instead of having to travel to a medical facility to receive virtual care from a distant site. They have also allowed Medicare patients located in urban and suburban areas to have access to telehealth services for the first time. COVID–19 flexibilities also enabled patients to access health care services through audio-only visits when they do not have reliable access to two-way audio-video telecommunications technology.

Passage of the Telehealth Modernization Act (S. 3967/H.R. 7623), which was introduced by Senators Tim Scott (R–SC) and Brian Schatz (D–HI) in the Senate, and Representatives Buddy Carter (R–GA), Lisa Blunt Rochester (D–DE), Greg Steube (R–FL), Terri Sewell (D–AL), Mariannette Miller Meeks (R–IA), Jeff Van Drew (R–NJ), and Joe Morelle (D–NY) in the House, is also crucial because in addition to eliminating the originating and geographic restrictions of Medicare coverage for telehealth, it would permanently continue the ability to use audio-only telehealth services beyond the current statutory deadline of December 31, 2024. Access to two-way audio-visual telehealth and audio-only services has lowered or eliminated bar-

riers that many patients in rural and underserved areas face when trying to obtain in-person care, such as functional limitations that make it difficult to travel to physician offices, long travel times, workforce shortages, the need for a caregiver to accompany the patient, and patients experiencing unstable housing and lack of transportation and childcare.

Permanently removing the antiquated geographic restrictions and the originating site requirements means patients will no longer have to travel, counterintuitively, to a limited set of brick-and mortar medical sites to access virtual care. In an effort to boost access to virtual mental health services, The Connect for Health Act also repeals the requirement within the Consolidated Appropriations Act, 2021, requiring patients to see a physician in-person within 6 months of an initial telehealth visit for a mental health condition.

The integration of this legislation would be a forward-thinking approach to the way health care is delivered, particularly for chronic disease management. These acts collectively aim to dismantle outdated barriers that restrict telehealth's potential to enhance patient care. By permanently removing these restrictions. This is especially important for chronic care management where the need for regular and convenient access to health care services is necessary.

Telemental Health Care Access Act

Federal lawmakers have also introduced stand-alone bills, specifically S. 3651/H.R. 3432, the Telemental Health Care Access Act, to remove these in-person visit requirements that will only stifle access to mental health services. While federal lawmakers have, thus far, passed legislation delaying the mandate for patients to receive an in-person visit within 6 months of receiving an initial telemental health service from taking effect, it is crucial this policy is permanently removed to ensure patients retain ample access to virtual mental health services. Absent Congressional intervention, the in-person telemental health requirements will go into effect on January 1, 2025, so it is crucial legislative action occurs expeditiously.

The dramatic increase in the availability of telehealth services has catalyzed the development and diffusion of innovative hybrid models of care delivery utilizing in-person, telehealth, and remote monitoring services so that patients can obtain the optimal mix of service modalities to meet their health care needs. These models can also reduce fragmentation in care by allowing patients to obtain telehealth services from their regular physicians instead of having to utilize separate telehealth-only companies that may not coordinate care with patients' medical home. Now, all Americans, including rural, underserved, minoritized and marginalized patients, can receive a combination of in-person and virtual care, which is crucial for patients with chronic diseases. Congress should not permit these flexibilities to expire as it will run counter to its goals of promoting more home-based care.

In closing, the AMA looks forward to working with the Senate Finance Committee to pass the above-mentioned proposals that help promote prevention, the use of telehealth for chronic care management and continuity of care, provides for the solvency of independent physician practices (which form the bedrock of care for rural and underserved communities and our health care system in general), and eliminates the burdens many physician practices face to receive electronic payments for services rendered. The more we can stabilize the Medicare program and reduce the burdens that physician practices face, the more time and resources there are available to dedicate to improving patient care. We stand ready to work with the Committee to improve the Medicare program for the patients struggling with chronic conditions and the physicians who treat them.

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April 10, 2024

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
 Ranking Member
 Senate Committee on Finance
 219 Dirksen Senate Office Building
 Washington, DC 20510

Dear Senator Wyden and Senator Crapo,

I am writing to share perspectives on the upcoming Senate Finance Committee hearing “Bolstering Chronic Care through Medicare Physician Payment Reform” scheduled to take place in the Senate Finance Committee on April 11, 2024. This discussion represents a critical opportunity to enhance the quality of care for individuals living with chronic conditions and to address systemic challenges within our healthcare system. Thank you for holding this discussion.

Chronic diseases present formidable challenges for both patients and healthcare providers, necessitating ongoing management and support. By reforming Medicare physician payment structures to incentivize comprehensive, coordinated care for chronic conditions, we can revolutionize how we approach chronic care management. Adequately compensating physicians for their time and resources invested in managing chronic conditions is essential to ensuring that patients receive the comprehensive support they need to lead healthier lives.

Moreover, implementing payment reforms aligned with the goals of chronic care management has the potential to reduce healthcare costs in the long term by minimizing hospitalizations, emergency room visits, and complications associated with unmanaged chronic conditions. Prioritizing preventive care and proactive management is crucial for creating a more sustainable and efficient healthcare system.

Additionally, I urge the Senate Finance Committee to recognize the growing impact of obesity as a chronic disease and to consider the implications of Medicare coverage for anti-obesity medications under the Treat and Reduce Obesity Act (TROA). Currently, Medicare Part D does not provide coverage for these medications, despite their proven efficacy in helping individuals achieve significant weight loss and reducing the risk of developing chronic diseases such as diabetes and heart disease. TROA would address this gap by providing coverage for anti-obesity medications as well as the full range of obesity treatments, including nutrition counseling, behavioral therapy, and community-based programs.

I commend the Senate Finance Committee for taking proactive steps to address these pressing issues and for their dedication to advancing healthcare. I hope that you will share these points with the committee members during the upcoming discussion. I eagerly anticipate the livestream of the hearing and look forward to the progress that will be made in bolstering chronic care and addressing the needs of patients with chronic conditions.

Thank you for your attention to these important matters.

Sincerely,

Eliza Chin, M.D., MPH
 Executive Director

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April 23, 2024

The Hon. Ron Wyden
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 219 Senate Dirksen Office Building
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The Hon. Mike Crapo
 Ranking Member
 United States Senate
 Committee on Finance
 219 Senate Dirksen Office Building
 Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the American Nurses Association (ANA), I would like to thank you for holding the hearing, “Bolstering Chronic Care through Medicare Physician Payment,” on April 11, 2024. While physician payment has been discussed for decades, there also needs to be focus placed on how public payers such as Medicare ensure

access to nursing care. The roles registered nurses (RN) and advanced practice registered nurses (APRN) play in health care delivery has changed significantly since the inception of the Medicare program.

ANA appreciates the Committee's recognition that more fully valuing primary care providers is essential to helping the Medicare program better address chronic conditions. The shortage of primary care physicians in the United States is projected to be between 20,200 and 40,400 physicians by 2036.¹ Consequently, APRNs will be needed to fill this void in primary care, and they stand ready to be utilized to the fullest extent of their education and clinical training—Nurse Practitioners (NP), for example, already make up around 50 percent of the primary care workforce. Appropriately, Medicare rules and statements increasingly refer to Qualified Health Practitioners (QHP), in addition to physicians, in order to be more inclusive of APRNs. ANA would appreciate the Committee's urging of the Centers for Medicare and Medicaid Services (CMS) to continue to do so. Moreover, RNs are significant providers of care coordination and related services that render team-based care effective for patients with chronic conditions. We appreciate this opportunity to share with you how several of our policy priorities align with the Committee's goals for physician payment reform.

ANA is the premier organization representing the interests of the nation's over 5 million registered nurses, through its constituent and state nurses associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include those practicing in the four advanced registered nurse roles: NPs, clinical nurse specialists (CNS), certified nurse-midwives (CNM), and certified registered nurse anesthetists (CRNA). ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

National Provider Identifier (NPI) Numbers for All Practitioners

NPIs remain the gold standard for determining eligibility and reimbursing the health care clinicians for care provided to patients. RNs are integral parts of the health care team and spend significant time with patients providing clinical services. However, though they are eligible to receive them, NPIs are not required for RNs and they do not typically obtain them. In the current health care financing system, RN work is generally not accounted for, other than in the practice expense (PE) component of the relative value unit (RVU). The time spent by the RN is the main element of RN work that is captured in the PE of billing providers. **The lack of NPIs for nurses makes it extremely difficult to record, measure, and value the services they provide and their impact on patient outcomes.**

Obtaining an NPI is a first step to recognizing and evaluating the value of the nurse in the health care delivery system. Obtaining and recording RNs' NPIs in relevant health care data systems would allow health systems, payers, and enterprise resource planning systems to distinguish the value of nursing services from that of other providers. This would allow for a quantitative analysis and substantive demonstration of the nurse's role and value as an integral member of a patient's health care team. As such, ANA urges the Committee to explore utilization of the NPI for RNs as a means of better capturing the significant contributions of RN care. NPIs would not change RN reimbursement or pay as RN times and services provided are now included in the PE component of relative value unit RVUs.

Recognizing RN Value

As the Committee looks at ways to evolve and reform the health care system, ANA strongly advocates for changes in current reimbursement models to recognize the value of the nurse. The American Medical Association (AMA) created the CPT and RUC systems to value the work done by physicians and other qualified healthcare providers. While APRNs and other non-physician providers have NPIs and bill for services attributed to them, patient care provided by RNs is not billed and identified separately. The result is that RNs have historically been included as part of PE when the RUC either establishes or modifies the value of procedures in the CPT code set. However, this only captures the time it takes rather than fully capturing the scope of services that RNs provide to patients. Payment innovations centered

¹<https://www.aamc.org/media/75231/download?attachment>.

on value should encompass the expertise of RNs and the clinical services they provide. As such, ANA encourages the Committee to explore reimbursement models that would capture the actual value of the RN as part of any broader Medicare payment reforms.

Incident To Billing

In the same vein as assigning NPI numbers to RNs, MedPAC has recommended for several years that Congress should require APRNs and physician assistants to bill the Medicare program directly, eliminating “incident to” billing for services they provide.² ANA agrees with MedPAC. Because of incident to billing, it is unknown what care is being delivered by physicians directly or by other practitioners. The data generated by eliminating incident to billing would give Congress and other policymakers a more complete understanding of how our health care system is working and will help uncover efficiencies and cost savings. Not only would eliminating incident to billing generate cost savings, but we believe the benefits of the data derived will provide significant value to policymakers, particularly with respect to appropriately valuing primary care.

Discounted Reimbursement for Nurse Practitioners and Clinical Nurse Specialists

Under current law, NPs and CNSs receive 85 percent of the Physician Fee Schedule for the same work as their physician colleagues. In addition, only physicians receive a 10 percent bonus if they work in designated health professional shortage areas (HPSA), meaning NPs and CNSs receive less than 78 percent of the reimbursement as their physician colleagues for the same work in HPSAs. Furthermore, practice expenses do not change based on your professional designation. There is no reason the discounted reimbursement should include a discount on practice expenses when a difference between practice expenses of those of a physician and those of another qualified provider does not exist.

APRNs are educated under the nursing model, where clinical training is integrated into their core curriculum. APRN programs are competency-based, not time-based. A student must demonstrate mastery of content before advancing. While the nursing and medical models of training are different, the safety and quality of APRN competency-based education is consistently demonstrated in more than 40 years of patient care research. For example, the American Enterprise Institute released a report that found that “beneficiaries who received their primary care from NPs consistently received significantly higher-quality care than physicians’ patients in several respects. While beneficiaries treated by physicians received slightly better services in a few realms, the differences were marginal.”³ ANA appreciates the Committee’s recognition of the need to bolster primary care in rural and underserved areas and expanding the 10% HPSA bonus eligibility for APRNs is a commonsense way to help address this growing challenge.

Improving Care and Access to Nurses (ICAN) Act (S. 2418/H.R. 2713)

ANA reiterates our staunch support for the ICAN Act, which contains a host of provisions that would increase access to cost-effective, high-quality care for Medicare and Medicaid beneficiaries. This legislation would increase patient access to care by removing outdated and unnecessary federal barriers on services provided by APRNs under the Medicare and Medicaid programs, further benefiting beneficiaries, especially those with chronic care conditions that must be closely monitored.

Recognizing the importance of APRNs to our health care workforce, and for patient access to care, the Institute of Medicine (IOM) issued *The Future of Nursing: Leading Change, Advancing Health* report in 2010, which called for the removal of laws, regulations, and policies that prevent APRNs from providing the full scope of health care services they are educated and trained to provide. In 2021, this position was reaffirmed by the National Academy of Medicine (previously named the IOM) in their 2021 *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity*.

Unfortunately, there are still Medicare and Medicaid policies that have not been modernized to reflect the growing and essential role of APRNs. Various federal statutes and regulations remain which prevent APRNs from practicing to the full extent of their education and clinical training. Many of these policies were written before APRNs could participate in Medicare. These provisions reduce access to care, dis-

² <https://www.medpac.gov/recommendation/issues-in-medicare-beneficiaries-access-to-primary-care-5-1-june-2019/>.

³ <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/>.

rupt continuity of care, increase health care costs, and undermine quality improvement efforts. Removal of these outdated barriers should serve as a bedrock of Medicare reimbursement reform.

The purpose of the *ICAN Act* is to increase access, improve quality of care, and lower costs in the Medicare and Medicaid programs by removing federal barriers to practice for APRNs, *consistent with state law*. We urge Congress to pass this important legislation. It will move our health care system forward in an effective and efficient manner for the benefit of patients and providers. More than 240 organizations have endorsed this legislation, including the National Rural Health Association, AARP, the American Health Care Association, and Leading Age.

In closing, I would like to thank you for your leadership and for your willingness to consider our perspective on this critical issue to ensure that patients have access to qualified, high-quality providers. ANA stands ready to work with the Finance Committee to implement policy solutions to comprehensively address the nation's challenges addressing chronic care. If you have any questions, please contact Tim Nanof, Vice President of Policy and Government Affairs, at (301) 628-5081 or Tim.Nanof@ana.org.

Sincerely,

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The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 230,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting participation in daily occupations or activities. In so doing, growth, development, and overall functional abilities are enhanced, and the effects associated with illness, injuries, and disability are minimized.

Crucial Role of Occupational Therapy in Supporting Chronic Conditions

Occupational therapy (OT) can contribute to the overall effectiveness of a primary care program focused on managing and supporting chronic conditions. However, OT has faced increasing challenges providing services under the Medicare Physician Fee Schedule over the last decade, even as more and more evidence emerges about the efficacy of OT in improving the overall health and wellness of Medicare Beneficiaries.

At its most basic, the goal of occupational therapy is to evaluate the person, their needs, and their capabilities to optimize their ability to perform day-to-day activities and to maximize health. Occupational therapy self-management interventions can improve the health outcomes in type 2 diabetes and provide a cost-effective option for reducing the burdens placed on patients and healthcare systems.¹ Supporting self-management facilitates individuals' ability to function in their desired environment, often preventing higher utilization of more costly care.

Occupational therapy enables individuals with a chronic condition to have healthier, productive, and meaningful lives by:

- Addressing performance deficits in daily self-care (ADLs) and home management tasks (instrumental ADLs), resulting from specific chronic conditions, to sustain or improve current status in these areas.
- Developing strategies to incorporate energy conservation and activity modification techniques into daily activities to cope with physical demands and reduce the fatigue associated with many chronic conditions.

¹Self-Management Support Interventions Integrated into Occupational Therapy Practice With People Having Type 2 Diabetes. <https://natsci.upit.ro/issues/2019/volume-8-issue-16/self-management-support-interventions-integrated-into-occupational-therapy-practice-with-people-having-type-2-diabetes>.

- Individualizing adaptations to perform health management tasks effectively (*e.g.*, ensuring that someone with hand weakness can manage daily insulin shots for diabetes).
- Teaching and incorporating health management tasks into existing habits and routines, so they become part of the daily routine (*e.g.*, setting up a schedule and reminder system to take medications).
- Developing coping strategies, behaviors, habits, routines, and lifestyle adaptations to support physical and psychosocial health and well-being.

Building Routines and Habits for Overall Self-Management of Conditions

Living with a chronic condition can bring with it changing physical and/or mental abilities. In addition, the environment, both physical and psychosocial (*e.g.*, family dynamics), may need to be addressed. Occupational therapy practitioners analyze the demands of activities meaningful to the client and evaluate the fit between abilities and challenges.

Self-management is about taking charge of one's life and managing one's condition instead of being controlled by that condition and is recognized as an effective approach to chronic health conditions by "empowering patients to understand their conditions and take responsibility for their health".² The client-centered nature of occupational therapy is ideal for supporting self-management. Whether a client is newly diagnosed or has lived with a chronic condition for many years, occupational therapy supports patients in managing the disease with positive behaviors and strategies while also engaging in daily life activities.

Occupational therapy practitioners analyze the demands of meaningful activities to the client and evaluate the fit between client abilities and challenges imposed by those activities and the environment. They may make recommendations on conserving energy, decreasing or preventing pain, simplifying activities, and improving the safety and ease of functioning in a given environment (*e.g.*, home, school, work).

Managing chronic conditions also involves learning specific health-management skills. These may include regularly monitoring blood pressure or weight; planning, shopping for, and preparing meals according to specific requirements or restrictions; monitoring blood glucose; administering oral, injected, or inhaled medications; or increasing physical activity. It is not enough for clients to learn and demonstrate these skills. To be effective, they must be consistently, habitually, and correctly performed and the client must successfully integrate those skills into existing routines. Occupational therapy practitioners look at barriers that prevent clients from integrating health management tasks into their daily routines and, if necessary, incorporate adaptations to overcome these barriers. They are particularly skilled in helping clients manage chronic conditions in a way that fits with existing routines and patterns, so changes feel less disruptive and are more likely to be consistently integrated into the daily routine.

Focus on Developing Medication Management Strategies

Medication non-adherence in patients with chronic conditions results in higher hospitalization rates, poorer outcomes, and dramatically increased health care costs. Studies have shown that between 50–70% of older adults fail to take medications according to physician instructions—resulting in an estimated 3 million older adults being admitted to skilled nursing facilities each year and causing as many as 125,000 deaths annually.³

As experts in the development of habits and routines, as noted above, occupational therapy practitioners play a pivotal role in helping patients develop medication management routines. Working with occupational therapy practitioners to establish daily practices aimed at significantly improving medication compliance have proven to increase overall health and functional status, decrease the risk of falls, improve cognition, and increase driver safety for older adults.⁴

Studies in this area indicate that medication habits need to be customized to the individual to promote integration into existing life routines. This finding is consistent with client-centered practice. Evidence also strongly suggests that patients would significantly benefit from skilled interventions, such as developing cues, arranging for equipment, assessing the environment, or arranging for monthly refills.

²<https://www.ninr.nih.gov/sites/files/docs/ninr-focus-self-management.pdf>.

³<https://pubmed.ncbi.nlm.nih.gov/14717268>.

⁴https://www.researchgate.net/publication/284362391_Relationship_of_Number_of_Medications_to_Functional_Status_Health_and_Quality_of_Life_for_the_Frail_Home-Based_Older_Adult.

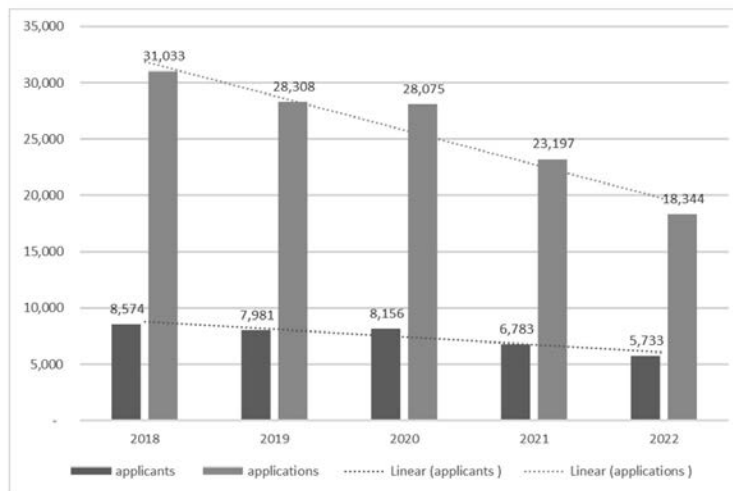
These findings substantiate occupational therapy practitioners' role in developing specific, individualized, concrete plans for integrating medical devices, thus exponentially increasing the patient's odds of adherence.

Alarming Trends in the Occupational Therapy Workforce Threaten Future Access to Care

Occupational therapy (OT) services are provided by both occupational therapists (who are trained either through a 2-year master's program or a 3-year doctoral program) and occupational therapy assistants (who either receive an associate's degree or a bachelor's degree).

Since 2018, there has been a steady decrease in the number of applicants (–33%) and total applications (–41%) to OT programs. Occupational therapy assistant programs have seen the most significant of these declines. In 2015 these programs filled 85% of their available seats. In 2022, only 66% of seats were filled—a 19% decrease.

However, the U. S. Bureau of Labor Statistics projects an increase in the need for occupational therapy practitioners (OTPs) over the next 10 years; projecting a 14% increase in employment for occupational therapists⁵ and a 25% increase in employment of occupational therapy assistants.⁶



The following recommendations focus on ways Congress can increase access to innovative programs under Medicare, ensure adequate payment for occupational therapy services, ensure that occupational therapy practitioners are included in future payment models that focus on beneficiary outcomes, and ensure beneficiary access to occupational therapy services in rural and medically underserved areas.

Congress Must Increase Access to Innovative Programs

Cost Savings Through Supporting Aging in Place and Reducing Falls. Multiple programs and studies have demonstrated the effectiveness and cost savings of an occupational therapy-led home-safety evaluation centered on a client's identified goals and preferences and followed by suggested low-cost home modifications and adaptive equipment. Despite demonstrated cost savings and improved quality of life, there is no way for these types of services to be provided to Medicare beneficiaries outside of grant funding and demonstration projects.

The CAPABLE Model, which was developed through funding by the Center for Medicare and Medicaid Innovation (CMMI) and the National Institutes of Health

⁵ <https://www.bls.gov/ooh/healthcare/occupational-therapists.htm#tab-6>.

⁶ <https://www.bls.gov/ooh/healthcare/occupational-therapy-assistants-and-aides.htm#tab-6>.

is the most well-known of these interventions. This 5-month, interprofessional, team-based intervention is delivered by an occupational therapist (six visits), a nurse (four visits), and a handy-person (up to 1 day). The handy-person will make home repairs, install assistive devices, and make home modifications as prescribed by the occupational therapist. CAPABLE as American Occupational Therapy Association Page 2 of 5 a model promotes safe and effective aging in place by addressing Medicare beneficiary issues that directly drive healthcare costs yet are not addressed in current care models. The model has resulted in reduced disability, healthcare cost savings, and the promotion of aging in place. Studies have demonstrated that the CAPABLE model produced \$922 per Medicare beneficiary per month in savings for up to 2 years⁷ and \$867 per month for up to a year in Medicaid savings⁸ due to a reduction in hospitalizations and other institutional based care.

While the CAPABLE model has undergone multiple clinical trials and studies, there is other ample evidence for the cost-effectiveness of low cost, high intensity home modifications directed by an occupational therapist. A study in the *American Journal of Preventative Medicine* identified “home modifications delivered by an occupational therapist” as the intervention with the greatest potential to help older adults by preventing falls. The study estimated a cost savings of \$38.2 million and estimated that 45,164 falls would be prevented.⁹ Another study combined weatherization/energy services with a home safety assessment conducted by an occupational therapist and subsequent home modifications/repairs. The study group saw a significant reduction in falls (from 94% to 9%) and calls for assistance (from 23% to 3%) within a 6-month period.¹⁰

When Congress directed the Department of Housing and Urban Development (HUD) to establish a grant program to help enable low-income elderly persons to remain in their primary residence, HUD chose OT to lead home modifications as the intervention with the most evidence of success and cost savings and also based the Older Adults Home Modification Grant Program (OAHMP) around this intervention model.¹¹ The grant program highlights that occupational therapy practitioners are “trained to evaluate clients’ functional abilities and the home environment” and have “knowledge of the range of low-cost, high-impact environmental modifications and adaptive equipment used to optimize the home environment and increase independence.”

Occupational therapy practitioners (OTPs) also play a distinct role in helping those with Alzheimer’s and dementia continue to engage in the activities that are most meaningful to them, thereby helping to optimize their quality of life. A crucial component of supporting meaningful engagement for a person with dementia, is supporting and training the caregiver, as well as promoting caregiver wellness, a focus of both Skills2Care© and COPE. While these programs are supported by the Administration on Aging and some state Medicaid programs, there is currently no pathway to reimbursement for these interventions under Medicare.

Congress has established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) so that ideas on value-based care could be generated from the diverse provider community. The ability of the PTAC to approve smaller, innovative Alternative Payment Models (APMs) is now more important than ever, as CMMI has pledged to focus on fewer, larger APMs. Despite the promise of the PTAC, however, it has failed to create a pathway for meaningful participation in APMs. The CAPABLE model is an example of an evidence-based intervention, approved by the PTAC, that was never implemented by CMS even though it was first developed through funding from CMMI research grants.

⁷Ruiz S, Snyder LP, Rotondo C, Cross-Barnet C, Colligan EM, Giuriceo K. Innovative Home Visit Models Associated with Reductions in Costs, Hospitalizations, and Emergency Department Use. *Health Affairs*. 2017;36(3):425–432.

⁸Szanton SL, Alfonso YN, Leff B, et al. Medicaid Cost Savings of a Preventive Home Visit Program for Disabled Older Adults. *Journal of the American Geriatrics Society*. 2018;66(3):614–620.

⁹Stevens, Judy A. and Robin Lee. “The Potential to Reduce Falls and Avert Costs by Clinically Managing Fall Risk.” *Am J Prev Med* 55 no. 3 (2018): 290–297. doi:10.1016/j.amepre.2018.04.035.

¹⁰Tohn, Ellen, Jonathan Wilson, Tracy Van Oss, and Michael Gurecka. “Incorporating Injury Prevention into Energy Weatherization Programs.” *J Public Health Manag Pract* (2019) doi:10.1097/PHH.0000000000000947.

¹¹https://www.hud.gov/program_offices/spm/gmomgmt/grantsinfo/fundingopps/oahmp.

Recommendations:

Congress could allow healthcare practitioners to pilot test PTAC-approved APM models: This is not allowed under current law, but granting such permission would allow participants to show CMS and other policymakers how the model would work and perform in real-world settings for the benefit of Medicare beneficiaries. Once the pilot period concludes and an appropriate amount of data was collected and analyzed, CMS could make its final approval or denial decision. If approved, this would allow for other providers to more easily replicate real-world use of the piloted model and build upon lessons learned to allow for more effective, broad-scale implementation.

Congress must be able to look beyond current CBO analysis when judging potential savings for innovative programs: Under current rules, CBO would not take into account the massive savings which would be generated by a national roll-out of CAPABLE or a similar program. Therefore, the cost would be prohibitively high, and real savings would not be realized as patients would continue to suffer preventable accidents which result in costly emergency room visits, hospitalizations and institutionalization.

Eroding Reimbursement under Medicare Part B

Occupational therapy practitioners and other therapy providers have been particularly hard hit by the recent redistribution of resources on the Physician Fee Schedule to increase payments for Evaluation & Management (E/M) codes as a result of budget neutrality requirements. Unlike other medical specialties, therapy providers are not allowed to bill evaluation and management codes, meaning therapy practitioners have taken and will continue to face the full reduction in the conversion factor caused by these payment changes. In addition to the decreases in the conversion factor caused by changes to the E/M values, payment for therapy services received additional cuts in 2024 after the Congressional moratorium on implementation of the G2211 code ended. We appreciate Congressional action to phase these cuts in, however at the end of this phase in, payment for occupational therapy services will have been reduced by as much as 9%.

The negative impacts of past and future budget neutrality cuts on OT are felt nationally; however, rural providers face greater challenges given that they serve smaller and often shrinking patient populations. Total Medicare payments for OT services increased nationwide from \$1.1B to \$1.6B from 2009–21 which represents a 37 percent increase; however, this was driven by a 48% increase in patient volume, not the number of services per beneficiary which actually dropped by 6.9% during this time. Given that the rural population in the U.S. has declined from nearly 59.5 million to 56.8 million during this time, downward pressures on reimbursement cannot be addressed by increased patient volume, which would be difficult to achieve anyway given decreases in applications for OT programs, OTA reimbursement cuts and other factors.

While the challenges of the current payment system cut across multiple specialties, they have been particularly difficult for therapy providers, including occupational therapy practitioners. From the beginning, the Quality Payment Program (QPP) offered few options for participation for therapy practitioners, and outpatient therapy services provided in facility-based settings were never eligible for the QPP. Occupational therapy practitioners in private practice have limited or no options to receive bonus payments. As Congress considers policies to create a more affordable, patient-centered health care system focused on overall health, policies must include all Medicare-eligible professionals equally. Further, we ask that Congress consider updating legacy Medicare payment policies that continue to harm therapy providers and threaten access to care for Medicare beneficiaries.

Recommendations:

End the Multiple Procedure Payment Reduction (MPPR) for therapy services: The multiple procedure payment reduction (MPPR), is a payment policy that was first implemented in 2011, and applies to physical therapy (PT), occupational therapy (OT) and speech language pathology (SLP) services provided under Medicare Part B. Because of MPPR, when a beneficiary receives more than one 15-minute therapy services on the same day, all subsequent therapy services beyond the first, across therapy disciplines, are cut. Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all other subsequent therapy services are reduced by 50%.

The MPPR is a flawed policy that was never based on actual data backing the 50% reduction. The Centers for Medicare & Medicaid Services (CMS) initially proposed a 25% reduction, even while acknowledging that this number was not backed up with concrete data. Later Congress moved the 25% reduction to 50% in order to pay for a month's long patch to the Sustainable Growth Rate. As a result, therapy services received, which is now estimated to be a 15.8% cut to payments, only a few years before their payment rates were frozen under MACRA.

- The application of MPPR to the “always therapy” codes results in an excessive reduction of these codes and is having a significant impact on the financial viability of therapy practices and the occupational therapy workforce—ultimately impacting access to vital therapy services. We strongly recommend that Congress end this policy or reduce the level of cuts.

MACRA and the Medicare Quality Payment Program: In order to move to a payment system that truly values quality and patient outcomes, all providers must be engaged from the outset. CMS's current one-size-fits-all development of MIPS eligible quality measures has focused primarily on physicians and does not reflect the services (and outcomes) of many providers paid through the Medicare Physician Fee Schedule.

- CMS must provide a way for all providers to participate in current and future payment programs throughout their development. This includes identification of cost measures that occupational therapy practitioners can participate in, outcomes measures that are reflective of the services provided by occupational therapy practitioners and other non-physician providers, and outcomes measures that are not limited to the use of a specific outcomes management systems.

Allow Occupational Therapy Practitioners to Opt Out of Medicare: Unlike many other health providers, occupational therapy practitioners cannot opt out of being a Medicare enrolled provider, if they provide services to Medicare-eligible beneficiaries. This prevents Medicare beneficiaries from exercising their right should be empowered to select the health care professional of their choice, including allowing beneficiaries to privately contract with occupational therapists. As discussed below, Medicare's inflexible policies have stifled the ability to implement innovative programs that can support the long-term health and wellness of Medicare beneficiaries. There are evidence-based therapy interventions that cannot be reimbursed under current Medicare payment policies, but could be provided under private pay, if that were allowed.

- Allowing therapy providers to opt out would give Medicare beneficiaries the opportunity to benefit from these critical interventions to which they are currently denied access, and improve overall health outcomes, thus keeping people out of the acute healthcare system.

Ensuring Access to Occupational Therapy Services in Rural and Underserved Areas

Telehealth

OT interventions delivered via telehealth have enabled patients to develop, regain, and build functional independence in everyday life. Telehealth has also demonstrated advantages over in-person visits in some situations, especially for people in rural and underserved areas, and for the large number of seniors in all communities who face transportation and mobility issues, especially those with disabilities. Telehealth is also an ideal platform for conducting home safety evaluations as it provides a window into the person's home and often greater access to their caregivers. However, occupational therapy practitioners are only allowed to provide Medicare telehealth services under temporary waivers.

Recommendation:

Enact legislation such as S. 2880—the Expanded Telehealth Access Act in order to make therapy practitioners permanent Medicare telehealth providers. Congressional action is essential to enable Medicare beneficiaries to continue to receive OT services via telehealth when appropriate. Passage of the Expanded Telehealth Access Act (S.2880) would enable OT professionals as well as PTs, SLPs, and audiologists to *provide services via telehealth under Section 1834(m) of the Social Security Act*. Unless Congress acts, Medicare beneficiaries will face a telehealth “cliff” on December 31, 2024, whereby beneficiaries who are now accustomed to receiving some OT services via telehealth suddenly lose access to such services. We urge Congress to prevent this outcome.

Support Occupational Therapy Assistants

Access to occupational therapy in rural, medically underserved areas is directly dependent on the availability of occupational therapy assistants. An analysis of 2021 Medicare Part B claims¹² shows that 46% of all occupational therapy services provided in rural and medically underserved areas are provided by OTAs, compared to 34% in all other geographic areas. The recent trends in enrollment for occupational therapy assistant programs are particularly worrisome for rural and medically underserved areas, where beneficiaries already tend to receive fewer minutes of therapy in settings such as skilled nursing facilities, and where occupational therapy assistants provide a much higher percentage of those minutes.¹³

Current enrollment trends and projected workforce needs paint an alarming picture for the future of the occupational therapy workforce and people's ability to access occupational therapy services in rural and medically underserved areas. Compounding the enrollment challenge is a recent reimbursement cut for services provided by OTAs. On January 1, 2022, Medicare outpatient services provided by occupational therapy assistants and physical therapist assistants (PTAs) began receiving a 15% reduction in payment. This cut is the result of a provision in the Balanced Budget Act of 2018, and is separate from, and in addition to, other cuts to therapy payments under the Medicare Physician Fee Schedule that have been imposed over the last several years.

Recommendation:

Enact the Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation (EMPOWER) Act (H.R. 4878/ S. 2459): The EMPOWER Act would change the Medicare supervision requirement for OTAs and PTAs in private practice so that it cannot exceed requirements under State law. Currently, private practice is the only setting under Medicare Part B that requires "direct" supervision instead of "general" supervision. Therapy providers in all settings must comply with their state practice act if state or local practice requirements are more stringent than Medicare, and currently 48 states require general supervision of physical therapist assistants, and 49 states require general supervision of occupational therapy assistants. This Medicare regulation, which only applies to private practices, is also more burdensome than in all other settings including those where more acute patients are generally seen, *i.e.*, hospital outpatient/SNF, etc.

- Enacting this bill would remove barriers to care provided by OTAs in a private practice setting and would reinforce the important role of occupational therapy assistants as part of the care team, especially in rural areas. The bill also requires the Government Accountability Office (GAO) to examine the impact of the 15% payment cut to OTAs and PTAs on access to services in rural and medically underserved areas. AOTA believes strongly that these cuts have already impacted access to services in rural and underserved areas, but more data is needed.

Thank you for your attention to this crucial issue. AOTA looks forward to working with the Senate Finance Committee as you seek to improve payments for Medicare services and support beneficiaries with chronic conditions.

AMERICAN OSTEOPATHIC ASSOCIATION

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On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to express our appreciation for the Committee's interest in improving patient access to care and making meaningful strides toward addressing the substantial gaps in Medicare fee for service payment. This is a particularly important opportunity to provide insight on matters impacting osteopathic physicians and our patients.

¹² <https://acrobat.adobe.com/link/track?uri=urn:aaid:scds:US:afa395e4-8b46-30fc-9687-fd85ecb1aa95>.

¹³ <https://www.aota.org/-/media/corporate/files/advocacy/federal/otaworkforceinsnfsfinalreport922.pdf>.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. We recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals with chronic diseases have access to high-quality, continuing and comprehensive care when and where they need it. As such, the AOA unequivocally believes that the current Medicare physician payment model cannot sufficiently provide the stability physicians need to be able to deliver coordinated, longitudinal care—particularly for patients with chronic diseases.

Medicare Payment and Patient Access

Nearly 95 percent of adults aged 60 and older have at least one chronic illness or condition, and nearly 80 percent of the same cohort have two or more chronic conditions.¹ Over the next decade, the projected number of patients with at least one chronic condition is expected to double and encompass more than 142 million Americans by 2050, placing increasing strain on the U.S. healthcare system and workforce.² At the same time, the United States could see a shortage of as much as 124,000 physicians by 2034 if the current trends are not reversed.³ The current structure and unsustainable rates for physician payment is a key driver in practice closures and physician shortages, particularly in rural areas.

Physicians across the country face ongoing uncertainty regarding the payment they will receive for services rendered year after year. This year, in the Medicare Physician Fee Schedule CMS finalized a 3.37% cut to Medicare's physician payments, which was only able to be partially mitigated by Congress. This cut coincides with ongoing increases in costs to practice medicine—which CMS acknowledges, as the projected increase in the Medicare Economic Index (MEI) for 2024 will be 4.6%. **Unlike nearly all other Medicare providers and suppliers, physicians do not receive an annual inflationary payment update.** Changing this would provide stability to independent physician practices facing unique economic challenges in rural areas. This type of reform has previously been proposed through the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R. 2474), and **the AOA strongly urges the Senate Finance Committee to consider this legislation further.**

The AOA also recommends further supplementing support for rural physicians by utilizing economic levers that would make practicing in rural and underserved communities more accessible and appealing to a broader base of physicians. These levers include increasing Physician Health Professional Shortage Area incentives and/or creating new means of improving payment specifically for rural physicians. For example, in its March 2024 report, MedPAC recommended creating an add-on payment for physicians caring for low-income patients to better support physicians working with rural and underserved populations.⁴ Without predictable inflationary payment updates and additional incentives for rural and underserved areas, the physician workforce in these communities is likely to decline.

Furthermore, Medicare's current budget neutrality obligations within the physician payment schedule exacerbate the lack of inflationary updates. A provision within the Omnibus Budget Reconciliation Act of 1989 mandated that any adjustments to the MPFS due to upward payments or new procedures in one category that increase costs by \$20 million or more must be offset by cuts in other areas of the fee schedule. This issue is reflected in the implementation of a new and controversial care complexity add-on code (G2211). Improved payment for longitudinal, coordinated primary care is necessary for physicians, but those payment improvements should not come at the expense of payment reductions in other specialties that would limit the benefits the new code provides.

¹National Council on Aging. Chronic Inequities: Measuring Disease Cost Burden Among Older Adults in the U.S. A Health and Retirement Study Analysis. Page 5, Figure 2. April 2022. Accessed online at: <https://ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults>.

²Ansah JP, Chiu CT. Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Front Public Health*. 2023 Jan 13;10:1082183. doi: 10.3389/fpubh.2022.1082183. PMID: 36711415; PMCID: PMC9881650.

³Association of American Medical Colleges: Report Reinforces Mounting Physician Shortage. June 11, 2021. Accessed online at: <https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage>.

⁴MedPAC. "March 2024 Report to Congress." April 18 2024. Accessed online at: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

In comparing the United States with nine other high-income nations, the United States has significantly lower rates of patients reporting a longstanding relationship with a primary care physician.⁵ At the same time, evidence shows that longitudinal relationships, which are integral to both the philosophy of osteopathic medicine and delivering high-quality care, lead to better management of chronic conditions and improved patient outcomes.⁶ Investment in the physician workforce, especially in primary care, is needed to build capacity across the country. **To help alleviate building pressure on the physician workforce and subsequent access impacts upon patients, the AOA strongly urges the Committee to consider the *Resident Physician Shortage Reduction Act* (H.R. 2389).** The bill would increase the number of residency positions funded by Medicare, with particular emphasis on hospitals in rural areas and Health Professional Shortage Areas (HPSAs).

Additionally, the Committee should evaluate proposals such as the bipartisan *Rural Physician Workforce Production Act* (H.R. 834), which would allow certain hospitals to receive additional payments from Medicare for employing resident physicians in rural areas. This would increase the number of physicians practicing in rural communities and would provide financial support to make these residencies more accessible.

Continued patient access to high-quality care, particularly for chronic conditions, is contingent upon the confluence of all three factors: sustainable and predictable updates to physician payment under the Medicare Physician Fee Schedule, adjustments to the budget neutrality threshold, and investment in the physician workforce, particularly in rural and underserved communities.

Aligning Sites of Service and Medicare Payment

Differences in payment predicated upon the site of service create fundamental inequities in the care delivery landscape, and the MPFS cuts that went into effect January 1, 2024, would exacerbate existing site of service differences for services that are demonstrably similar. AOA supports policies that would require payments to physicians that reflect the resources required to provide patient care in each setting. These changes would also ensure that physicians delivering longitudinal care to patients with chronic conditions are not disadvantaged compared to Hospital Outpatient Departments (HOPDs) delivering urgent care for emerging issues related to chronic conditions. Not only would more equitable payment lower costs, but it would support better outcomes for patients.

The inequities, in the current payment model, allow for HOPDs to net higher payments for certain services, driving up costs to both Medicare and patients, while driving consolidation and reducing competition in the care delivery ecosystem. As the Committee considers policies that will align payments for various sites of service, it should prioritize payment models that account for costs incurred to the provider while also taking into account the nature of the patient population being served. Payment policies should also include factors such as the provision of care coordination, after-hours care, emergency care, quality-based payments, and other costs.

MedPAC recommended Congress implement site-neutral payment policies in its July 2023 report, and the AOA strongly echoes that recommendation.⁷

Value and Innovation

The AOA has long advocated for payment predicated upon delivering high-quality, value-based care rather than the volume-based nature of the current fee-for-service payment model. Despite that, transitions to value-based payments must account for the unique needs of different specialties, practices current capacities, and the ways physicians deliver care. It also must not create additional barriers to entry, result in reduced or inequitable payment, or increase administrative burden. To better promote high-value care and reduce burdens, the Committee should look at Advanced alternative payment models (APMs) rather than the Merit-based Incentive Payment System (MIPS) when building new policies.

⁵ Gumas ED et al. "Finger on the Pulse: The State of Primary Care in the U.S. and Nine Other Countries," March 28, 2024. The Commonwealth Fund. Accessed online at: <https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/finger-on-pulse-primary-care-us-nine-countries>.

⁶ Jennifer Arnold, "Fostering Long-Term Doctor-Patient Relationships to Improve Outcomes," Duke Health, January 17, 2017.

⁷ MedPAC. "Health Care Spending and the Medicare Program: July 2023 Data Book." 2023.

Advanced APM pathways include Accountable Care Organizations (ACOs), including those under the Medicare Shared Savings Program (MSSP), and Centers for Medicare and Medicaid Innovation (CMMI) models. Many AAPMs are well suited for physicians helping patients manage chronic conditions, as they include added incentives for providers who take on additional risk when treating patients as they deliver high quality, coordinated, and efficient care. Ultimately, in considering any shifts towards expanding existing APMs or seeking to accelerate physician participation in such models, efforts must:

- Support practices in making the necessary infrastructure investments to succeed under such models;
- Ensure sufficient flexibility in the range of models available to account for differences across specialties and the ways different physicians deliver care;
- Minimize administrative burden to enable physicians who commit to value-based models to focus on patient care; and
- Ensure adequate payment for the range of services the particular physician provides, and in the case of primary care, support the comprehensive services that advanced primary care seeks to deliver.

Ensuring that financial support is available to incentivize this transition is essential, and the AOA applauds Congress' extension of AAPM bonuses for PY2024, despite our disappointment at the reduced bonus rate.

When Congress passed the *Medicare Access and CHIP Reauthorization Act* (MACRA) it clearly intended to deliver an accelerated pathway for physicians to participate in APMs. The transition to value-based payment has not materialized as Congress had hoped because practices have not been paid enough to be able to reinvest to have the capacity to succeed in APMs. It is important to note that most APMs are built upon the foundation of our FFS system, and continuously declining payment rates in FFS create a vicious cycle that only makes it more challenging to transition as revenue, and funds available to make investments, declines.

Moreover, the current structure of MIPS does not effectively measure performance on meaningful outcomes or accurately predict care quality, and it is not an effective means of delivering value and penalizes small and rural practices.

Further, the Committee should consider additional funding for the Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP-SURS) program. This program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access while lowering costs. Most small and rural providers do not have access to the technical or administrative staff necessary to ensure proper participation in the MIPS, which currently disadvantages small and independent physician practices. Physicians in small and rural practices consistently receive below-average MIPS scores, demonstrating that practice size and resources are better indicators of MIPS performance than patient outcomes. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering demonstrably better quality of care.⁸ Physician-owned practices deliver high-quality and cost-effective care regardless of health system affiliation, and this research demonstrates the technical and administrative disadvantage small and independent physician practices are currently facing. Ensuring physicians at small or rural practices can participate in APMs that incentivize high-quality, cost-effective care is integral to improving patient access to care for chronic conditions.

Value-based payment is an important tool that can be used to enhance access to primary care, particularly for patients with chronic conditions. The AOA applauds the Committee's interest in taking steps to ensure physician payment reform drives patients access to high-quality, affordable, coordinated care, and we look forward to working with the committee further.

Conclusion

Again, thank you for the opportunity to submit comments for the record. The Committee's work on these important issues will support the stability of both the physician workforce and patient access to affordable, high-quality care. The AOA and our members stand ready to assist the Committee at large as you consider new policies and legislation to improve patient access to care and minimize red tape for doctors. If you have any questions or if the AOA can be a resource, please contact AOA Vice

⁸Johnston K, Wiemken T, Hockenberry J, et al. Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA Netw Open*. 2020;3(24):984–992.

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The Honorable Ron Wyden
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The Honorable Mike Crapo
Ranking Member
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Dear Chairman Wyden and Ranking Member Crapo,

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association appreciates the opportunity to submit comments for the hearing “Bolstering Chronic Care through Medicare Physician Payment.”

APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists’ roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession’s vision of transforming society by optimizing movement to improve the human experience.

“The Economic Value of Physical Therapy in the United States”¹ a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants as part of multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs.

While the report highlights the economic value that physical therapy brings to the U.S. health care system, such value is not maximized due to the unique challenges faced by physical therapists under the Medicare Physician Fee Schedule (MPFS). Physical therapist and physical therapist assistants play a critical in the delivery of services to beneficiaries who have chronic care conditions; however, therapists and other non-physician providers who are paid under the MPFS are often overlooked when it comes to enacting meaningful reforms to payment and administrative burden challenges. To improve chronic care services, broader reforms to the current fee schedule to address these challenges must be made.

APTA’s comments below offer a series of policy recommendations for the committee’s consideration to decrease health care costs and reduce administrative burden that are supported by APTA’s recent economic report.² Our comments also mirror the recommendations laid out in the “Policy Principles of Outpatient Therapy Reform Under the Medicare Physician Fee Schedule”³ that provides a roadmap offering recommendations specific to outpatient therapy that need to be made for the continued sustainability of physical therapy under Medicare. The “Policy Principles of Outpatient Therapy Reform Under the Medicare Physician Fee Schedule” are endorsed by APTA, APTA Private Practice, the American Speech-Language-Hearing Association, and the American Occupational Therapy Association.

¹<https://www.valueofpt.com/>.

²https://www.valueofpt.com/globalassets/value-of-pt/economic_value_pt_u.s._report_from_apta-policy_paper-policy_makers.pdf.

³[https://apta111-my.sharepoint.com/personal/justinelliott_apta_org/Documents/Desktop/Policy_Principles_for_Outpatient_Therapy_Reform_under_the_Medicare_Physician_Fee_Schedule\(apta.org\)](https://apta111-my.sharepoint.com/personal/justinelliott_apta_org/Documents/Desktop/Policy_Principles_for_Outpatient_Therapy_Reform_under_the_Medicare_Physician_Fee_Schedule(apta.org)).

Background

The 2015 Medicare Access and CHIP Reauthorization Act, known as MACRA, replaced the flawed Sustainable Growth Rate formula with the Quality Payment Program, or QPP. The QPP comprises two tracks: the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Models, also known as AAPMs. The Centers for Medicare & Medicaid Services began implementing the QPP in 2017, with the eventual goal of moving providers out of MIPS and into AAPMs. There are a number of foundational issues with MACRA and the QPP that disproportionately impact nonphysician qualified health care providers such as physical therapists. In addition, there are logistical and operational barriers for therapists to participate in MIPS and AAPMs. Some of the current challenges facing therapy providers include:

MACRA Has Not Stabilized Payment Under the Medicare Physician Fee

Schedule. MACRA sought to stabilize payments by repealing the Sustainable Growth Rate formula and providing payment adjustments under the QPP. Despite that goal, these changes replaced relief from the growth rate cuts with payment cuts to the conversion factor—as a result, budget neutrality requirements limit the effectiveness of payment incentives provided under MIPS and have required annual legislative intervention to stave off untenable cuts to payment. Further, nonphysician providers, including therapists, have few options to receive payment adjustments under the QPP that would otherwise serve to offset payment cuts. In 2021, the average payment per therapy claim *was the same as it was in 2010*. Since 2021, therapy services have been cut further because of reductions to the conversion factor. An additional 15% cut to services provided by physical therapist assistants was implemented in 2023. This decrease in payment is simply not sustainable if we are to have a robust workforce that supports access to rehabilitation therapy services nationwide. Providers are suffering under a workforce shortage and MACRA policies are reducing resources needed for adequate therapists to meet patient access needs.

Inability of facility-based outpatient therapy providers to participate in bonus payment structures.

While outpatient private practice therapy services are paid under the Medicare Physician Fee Schedule, or MPFS, services provided in facility-based settings, such as hospital outpatient departments, rehabilitation agencies, and skilled nursing facilities are not considered to be a part of the MPFS. Rather, the 1997 Balanced Budget Act required that payments for facility-based outpatient therapy services be “based-on” the value of those services as set forward in the MPFS. While therapy services provided under the fee schedule are billed through an individual’s National Provider Identifier, all facility-based outpatient therapy services are billed through the facility, and not the individual therapist. This distinction is not insignificant. According to MedPAC,⁴ 63% of all Medicare outpatient therapy services are provided in facility-based settings, yet facility-based outpatient therapy providers have had no way to receive payment updates or bonus payments. However, these services are subject to budget neutrality cuts and any other policy affecting therapy payments through the physician fee schedule—such as the multiple procedure payment reduction, also known as MPPR, and cuts to services provided by physical therapist assistants.

- **QPP Does Not Promote Value-Based Care or Effectively Measure Quality of Care.** The QPP does not allow for adequate participation for therapists in either MIPS or AAPMs. The lack of appropriate quality metrics and a failure to include all outpatient providers of therapy services in MIPS and AAPMs have prevented the shift to value-based care. These problems are compounded by slow and ineffective mechanisms used to innovate within the QPP. This means physical therapists who were not fully considered in the QPP’s design still cannot meaningfully participate.
- **Barriers to Therapist Participation in MIPS.** Most physical therapists are not required to participate in MIPS but are encouraged to opt in to the program. However, extremely limited payment incentives serve to dissuade optional participation given that the cost of compliance outweighs even the highest historical incentives earned under the programs. Without specialty measurement sets, therapy cost measures, or otherwise comparable options

⁴https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_22_OPT_FINAL_SEC.pdf.

available to most physicians, therapists have few reasons to participate under the program and suffer compounding pay cuts under the MPFS without any opportunity for mitigation through the QPP.

- **CEHRT is a Threshold Barrier for Therapists in MIPS and AAPMs.** Promoting interoperability through Certified Electronic Health Record Technology, or CEHRT, was part of MACRA's original vision. AAPMs promote this by requiring CEHRT as a prerequisite for AAPM opportunities, and under MIPS providers are scored on the "promoting interoperability" measure category. CEHRT options are simply not available for physical therapists, as their requirements are costly, burdensome, and contain many requirements that are specific only to physicians. As a result, physical therapists cannot participate in AAPMs, and will receive scores of zero under MIPS in the interoperability category. Without vendors working to develop CEHRT for therapists (in part because there aren't enough potential users to justify vendors' expense of CEHRT development), these providers will never be able to participate meaningfully. Requirements must be relaxed or modified, otherwise physical therapists will continue to be assessed on an uneven playing field.
- **Barriers to Participation in AAPMs.** In addition to CEHRT as a threshold barrier to participation, the Qualifying Participant, or QP, threshold to earn incentives under the program also is not realistically achievable for physical therapists. Further, while there is a Partial QP designation, it does not offer any incentives to participate, and serves more to prepare clinicians who believe they would meet the QP threshold in the future. AAPMs could have therapist-specific thresholds or offer incentives for partial QPs to incentivize participation by therapists.

The challenges that MACRA has created for therapy providers are compounded by the current budget neutrality policies under the MPFS that have resulted in year-over-year cuts. Despite Congress's annual intervention since 2020 to provide additional funding to the fee schedule to mitigate the impact of the cuts, therapy providers still had to absorb multiple payment reductions. The challenges associated with budget neutrality threaten to re-create the decades-long problems created by the Sustainable Growth Rate; an urgently needed solution is necessary to prevent increased spending associated with temporary, year-end fixes.

Recommendations

To provide greater stability under the MPFS for nonphysician providers such as physical therapists, and to help account for a decade of cuts to payments to therapy services, we recommend the following policies be included in any legislative package aimed at reforming the Medicare Physician Fee Schedule to ensure patient access to care and stability of providers.

Eliminate the Multiple Procedure Payment Reduction Policy

The MPPR Policy, first implemented in 2011, applies to physical therapy, occupational therapy, and speech-language pathology services provided under Medicare Part B. Because of MPPR, when therapists bill more than one "always therapy" service (identified by CPT code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code.

Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy clinicians, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced. In the 2011 Medicare Physician Fee Schedule, CMS first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from January 1, 2011, to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress implemented a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR).

Our organizations have opposed the MPPR policy since its inception. It is inherently flawed, because the American Medical Association Relative Value Scale Update Committee, which assigns values to CPT codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided

in a single session were explicitly taken into account when relative values were established for these codes. The application of MPPR to the “always therapy” codes results in a duplicative and excessive reduction of these codes and is having a significant impact on the financial viability of therapy practices—ultimately impacting access to vital therapy services.

The percentage of payment reduction was arbitrarily decided by the 112th Congress and does not reflect actual utilization data regarding how many units of a therapy service are typically delivered in a treatment session, and it does not recognize that OT, PT, and SLP interventions are separate and distinct from each other. When CMS first proposed the MPPR, they purposefully did not consider how therapy services are provided in facility-based settings, even stating that it does “not believe it would have been appropriate for us to consider institutional patterns of care.”⁵ (See page 70.)

With the potential exception of greeting the patient, clinical staff activities that are elements of the practice expense are not duplicative in nature and should not be reduced in value, especially when delivering different services during the therapy session. For instance, if therapeutic exercises using hand weights are provided for one unit, followed by self-care retraining in the kitchen for one unit, then the equipment, supplies, and clinical staff activities are entirely separate for each of these procedures. Each requires its own disinfection, patient positioning, and other set-up and clean-up processes before and after the procedure. Under the current policy, despite those services being separate and distinct, and having a separate and distinct practice expense, payment for the second unit is reduced even though the values of the two codes do not include any duplicative cost.

MPPR also applies across therapy disciplines delivered on the same date regardless of the distinct services and supplies provided to the patient. While the first therapy discipline (e.g., physical therapy) would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline (e.g., occupational therapy or speech-language pathology) delivering services on that date would have all provided service units reduced. This occurs even though the expertise, equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided. This policy penalizes providers when scheduling multiple therapies on the same date, which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day to reduce the need for repeat visits to the clinic.

Provide Flexibility in the Supervision of Physical Therapy Assistants to Alleviate the Challenges Facing the Physical Therapist Workforce in Rural and Underserved Areas

Medicare allows for general supervision of occupational therapy assistants (OTAs) by occupational therapists, and physical therapist assistants (PTAs) by physical therapists in all settings, except for outpatient private practice under Part B, which requires direct supervision. While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 49 states is general supervision of PTAs, making this an outdated Medicare regulation—which arbitrarily applies only to private practice—more burdensome than almost all state requirements. Standardizing a general supervision requirement for private practices will help ensure continued patient access to needed therapy services and give small therapy businesses more workforce flexibility to meet the needs of beneficiaries.

The inconsistency of supervision policies between settings jeopardizes employment opportunities for OTAs and PTAs as well as the needs of Medicare beneficiaries in medically underserved and rural communities that rely so heavily on their services. Standardizing the supervision requirement from direct to general for private practices will help ensure continued patient access to needed therapy services and give private practices more flexibility in meeting the needs of beneficiaries. This small modification would better promote timely access to therapy services.

Congress should enact the Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation Act, or EMPOWER Act (H.R. 4878/S. 2459),⁶ bipartisan legislation⁷ that would assist the therapy workforce by permitting general

⁵ <https://www.govinfo.gov/content/pkg/FR-2010-11-29/pdf/2010-27969.pdf>.

⁶ <https://www.apta.org/advocacy/issues/medicare-physician-fee-schedule/position-paper-pta-differential>.

⁷ <https://www.congress.gov/bill/118th-congress/senate-bill/2459>.

supervision of physical therapist and occupational therapy assistants under Medicare Part B outpatient practices. According to an independent report published by Dobson DaVanzo & Associates in September 2022, this change in supervision is *estimated to save up to \$271 million over 10 years*.

The EMPOWER Act also direct the Government Accountability Office to conduct an analysis of how the Medicare Part B 15% payment differential for services provided by OTAs and PTAs, which went into effect in 2022, has impacted access to occupational therapy and physical therapy services in rural and medically underserved areas, across all Medicare Part B settings. Beneficiaries in those areas are twice as likely to receive OT or PT services from an assistant. Rehabilitation therapy providers report that rural areas suffer significantly from the ongoing workforce shortage. A GAO report will provide greatly needed information and data regarding the impact of this payment differential and how it disproportionately impacts these regions.

Reform MACRA to Allow Broader Participation by Therapy Providers

Within MACRA, the QPP has posed significant challenges to nonphysician providers, including PTs, OTs, and SLPs. Therapists in particular have struggled to meaningfully participate in MIPS or engage in AAPMs, in part because CMS has failed to pilot or implement several alternative payment and delivery models applicable to therapy providers. Congress must enact meaningful reforms to the QPP that recognize the value of therapy providers and allow them to provide effective oversight of the QPP to determine its effectiveness at measuring therapy performance and outcomes.

The value of any quality program depends on the ability of all providers to participate. To address the current shortcomings of the QPP including limited opportunities for therapists' participation in the program, Congress should authorize a stakeholder workgroup to identify barriers and develop recommendations for the Secretary of the Department of Health and Human Services on rulemaking to ensure that the QPP comprehensively measures the impact of all care received by Medicare beneficiaries.

Reduce the Impact of Inflation on Providers and the Patients They Serve

Providers paid under the Medicare Physician Fee Schedule do not receive the annual inflationary update upon which virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. Providing an annual inflationary payment update to the Medicare Physician Fee Schedule's conversion factor based on the Medicare Economic Index, or MEI, will provide much-needed stability to the Medicare payment system. The MEI is a measure of inflation faced by health care providers with respect to their practice costs and general wage levels.

Health care providers, including rehabilitation therapists, continue to face increasing challenges as they seek to provide Medicare beneficiaries with access to timely and quality care. Congress has taken action to mitigate some of the recent MPFS cuts on a temporary basis, nevertheless, reimbursement continues to decline. According to an American Medical Association analysis of Medicare Trustees data,⁸ when adjusted for inflation, Medicare payments to clinicians have declined by 26% from 2001 to 2023. The failure of the MPFS to keep pace with the true cost of providing care, combined with year-over-year cuts resulting from the application of budget neutrality, sequestration, and alternative payment and value-based care models that are unavailable to therapists, clearly demonstrates that the fee schedule is broken. Increasingly thin operating margins disproportionately affect small, independent, and rural practices, as well as those treating low-income or other historically under-resourced or marginalized patient communities—undermining efforts to improve equity in health care and social determinants of health.

An inflationary update will provide budgetary stability to clinicians—many of whom are small business owners—as they contend with a wide range of shifting economic factors such as increasing administrative burdens, staff salaries, office rent, and purchasing of essential technology. Providing an annual inflation update equal to the MEI for fee schedule payments is essential to enabling practices to better absorb payment distributions triggered by budget neutrality rules, performance adjustments, and periods of high inflation. A more stable payment system will also help providers to invest in their practices and implement new strategies to provide high-value care.

⁸<https://www.ama-assn.org/system/files/medicare-updates-inflation-chart.pdf>.

APTA strongly support the Strengthening Medicare for Patients and Providers Act (H.R. 2474),⁹ legislation that would provide such an annual inflationary update to the Physician Fee Schedule's conversion factor based on the Medicare Economic Index to help ensure patient access to the critical services our members provide. H.R. 2474 was introduced by Reps. Raul Ruiz, D-CA, Larry Bucshon R-IN, Ami Bera, D-CA, and Mariannette Miller-Meeks, R-IA.

Reduce Administrative Burden for Therapy Services Provided Under Medicare Part B

Medicare Part B guidelines permit Medicare beneficiaries to receive therapy evaluation and treatment services with or without a physician order. The PT, OT, or SLP may evaluate that patient, formulate a plan of care, and commence treatment in either instance. However, under current certification requirements, the therapy provider must submit the plan of care to the patient's physician *and have it signed* within 30 days in order to receive payment. If the deadline is approaching and the referring physician still hasn't returned the signed plan of care, the rules say it's up to the therapist to obtain that signature; without it, the PT is faced with halting treatment or face the prospect of not getting paid by Medicare.

Given the current pressures on therapy providers, including recent year-over-year fee schedule cuts, we are united in seeking opportunities to reduce administrative burden without compromising patient safety or quality of care as a way to mitigate the impact of these payment cuts for therapy providers and our physician colleagues, as well as to best serve our patients expeditiously and without financial risk to their therapy providers. The time and resources spent by both therapists and physicians in procuring a timely signature when a physician order is already present adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care.

Congress should enact legislation that would clarify a new care coordination model such that when outpatient therapy services are provided under a physician's order, the plan of care certification requirements shall be deemed satisfied if the qualified therapist submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. The order would confirm the physician's awareness of the therapy episode and proof of submission of the plan of care would demonstrate the coordination and collaboration between the physician and the therapist called for by CMS.

APTA strongly supports the Remove Duplicative Unnecessary Clerical Exchanges Act, or the REDUCE Act (H.R. 7279).¹⁰ This bipartisan bill would streamline the current plan of care certification requirement under Medicare Part B to reduce administrative burden and paperwork for physical therapists and physicians. The REDUCE Act was introduced in the U.S. House of Representatives by Reps. Don Davis, D-NC, and Lloyd Smucker, R-PA.

Provide Patient Choice Under Medicare

Currently, PTs, OTs, and SLPs may not opt out of being Medicare-enrolled providers if they provide services to Medicare-eligible beneficiaries. This prevents Medicare beneficiaries from exercising their right to select the health care professional of their choice, including allowing beneficiaries to privately contract with these therapists for their care regardless of whether the therapist has elected to enroll in Medicare. To provide true patient choice and ensure access to the most appropriate care, PTs, OTs, and SLPs must be able to opt out of the established enrollment rules set by the Medicare program and federal law along with physicians, physician assistants, dentists, podiatrists, optometrists, social workers, psychologists, nurse midwives, dietitians, and other eligible providers. Denying a patient access to a therapist with expertise because that provider is not enrolled in Medicare also negatively impacts patients' clinical outcomes and can lead to increased downstream costs to the system.

It is imperative that Medicare enrollees have the opportunity to choose the most appropriate provider and model of care to meet their needs. Medicare's inflexible policies have stifled implementation of innovative programs that can support the long-term health and wellness of Medicare beneficiaries. Certain evidence-based therapy interventions cannot be reimbursed under current Medicare payment policies. Al-

⁹ <https://www.apta.org/advocacy/issues/medicare-physician-fee-schedule/strengthening-medicare-for-patients-and-providers-act>.

¹⁰ <https://www.apta.org/advocacy/issues/administrative-burden/remove-duplicative-unnecessary-clerical-exchanges-act>.

lowing therapy providers to opt out would give Medicare beneficiaries the opportunity to benefit from these critical interventions to which they are currently denied access.

According to an independent report published by Dobson & Davanzo in October 2023, allowing physical therapists, occupational therapists, and speech-language pathologists the option to opt-out is estimated to *save \$139.6 million over 10 years*. The American Physical Therapy Association urges Congress to enact legislation that would provide physical therapists and other therapy providers with the ability to privately contract with Medicare beneficiaries.

Enact a Permanent Medicare Policy for Therapy Services Delivered via Telehealth

In response to the coronavirus public health emergency in 2020, Congress passed and the President signed into law legislation that authorized CMS to significantly expand Medicare's coverage of telehealth services during the public health emergency to protect the health and safety of Medicare patients. Under the authority of Section 1135 of the Social Security Act, CMS permitted virtually all medical providers, including physical therapists, occupational therapists, and speech-language pathologists, to provide services via telehealth to Medicare beneficiaries. In late 2022, Congress approved legislation that extended Medicare's telehealth flexibilities for another 2 years; Medical providers will be permitted to treat Medicare patients via telehealth until December 31, 2024. After that date, unless Congress acts, Medicare patients may lose coverage of telehealth visits.

Continued access to telehealth services provided by physical therapists, occupational therapists, and speech-language pathologists would allow Medicare beneficiaries to maintain access to critical health care services utilizing the method of delivery in-person or telehealth of their choice. The June 2023 MedPAC Report highlighted that over 90% of Medicare beneficiaries surveyed who had at least one telehealth visit with a clinician stated that they were very or somewhat satisfied. Additionally, clinicians surveyed by MedPAC indicated that, on average, less than 10% of their services were delivered via telehealth. Finally, a report by the HHS Office of Inspector General found that less than 0.2% of Medicare telehealth claims were considered high risk. Telehealth presents a way to provide access to care for patients both in rural and urban areas who may have trouble getting to appointments due to distance, mobility or transportation issues, or who cannot afford to take time off of work. Services delivered using telehealth also provide access to therapy in areas of our country where there simply are no therapists available. Telehealth has been demonstrated to be a service delivery mechanism that is used judiciously by health care providers in consultation with their patients who maintain high levels of satisfaction. Furthermore, initial data indicates concerns over fraud, waste, and abuse may not be as significant as initially feared.

APTA supports the Expanded Telehealth Access Act (H.R. 3875/S. 2880),¹¹ bipartisan legislation that would add therapy providers in private practice, as well as facility-based outpatient therapy providers under Medicare Part B, as permanent authorized providers of telehealth services under Medicare. H.R. 3875 was introduced by Reps. Mikie Sherrill, D-NJ, and Diana Harshbarger, R-TN. S. 2880 was introduced by Senators Steve Daines, R-MT, and Tina Smith, D-MN.

Conclusion

APTA appreciates the opportunity to share our perspective and recommendations to the committee that will provide long-term stability and reform to the Medicare Physician Fee Schedule. Should you have any questions, please contact justinelliott@apta.org. Thank you for your time and consideration.

Sincerely,

Roger Herr, PT, MPA
President

¹¹ <https://www.apta.org/advocacy/issues/telehealth/expanded-telehealth-access-act>.

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April 25, 2024

The Honorable Ron Wyden
 Chair
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 Committee on Finance
 219 Dirksen Senate Office Building
 Washington, DC 20510

The Honorable Mike Crapo
 Ranking Member
 U.S. Senate
 Committee on Finance
 219 Dirksen Senate Office Building
 Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Psychological Association Services (APA Services), we are writing to share comments and recommendations for consideration as part of your committee's April 11th hearing, "Bolstering Chronic Care through Medicare Physician Payment." APA Services is the companion organization of the American Psychological Association, which is the nation's largest scientific and professional non-profit organization representing the discipline and profession of psychology, as well as over 157,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

We applaud your committee's attention to improving Medicare healthcare provider reimbursement policies, as they are not adequately supporting high-quality, cost-effective health care for the program's beneficiaries. We share the concerns of the broad provider community regarding the consistent failure of payment updates for Part B providers to keep pace with inflation. Steadily eroding reimbursement rates are increasingly making Medicare participation unsustainable for psychologists and other providers. We strongly support proposals to raise the budget neutrality cap on adjustments to the Medicare Physician Fee Schedule (PFS), and to connect annual conversion factor increases to the Medicare Economic Index or similar measures of inflation. However, our comments today will focus on aspects of the Medicare fee schedule and proposed payment policies that specifically impact psychological services.

Because of their foundational importance, it is important for policymakers to understand that Medicare PFS payment formula methodologies for both work and practice expenses have consistently undervalued psychologists' services. This situation has been exacerbated by the statutory requirement that annual updates to the PFS be made in a budget neutral manner.

Work Valuation

As the committee has recognized, the Medicare fee schedule tends to undervalue cognitively intensive services, and psychologists' services are cognitively intensive. Thankfully, the Centers for Medicare and Medicaid Services (CMS) has recognized the need to set more appropriate work values for psychologists' services, and in the 2024 fee schedule CMS initiated a 19.1% increase in work relative value units (RVUs) for psychotherapy services over the next 4 years. However, CMS has not adopted a similar increase for psychological and neuropsychological testing and assessment services, which are as cognitively demanding as psychotherapy services.

Psychological assessment is the process of systematically collecting reliable and valid information about behavior from multiple sources to inform decisions about a patient's mental or behavioral functioning, typically for the purpose of diagnoses, treatment planning, or treatment evaluation. Domains assessed in a psychological assessment typically consist of mood/emotional conditions and symptoms, mental status, adaptive functioning, and behavioral and interpersonal adjustment, with evaluation of acuteness vs. chronicity, severity, degree of functional impairment, comorbidity, and prognosis where information is available. Psychological testing has been shown to provide both clinical and financial benefit in treating psychiatric disorders.¹

Neuropsychological assessments provide measurements of behavioral manifestations of central nervous system (CNS) disorders using techniques that provide objectivity, validity, and reliability. Information acquired from neuropsychological assessments

¹Durosini, I., & Aschieri, F. (2021). Therapeutic assessment efficacy: A meta-analysis. *Psychological Assessment*, 33(10), 962-972. <https://doi.org/10.1037/pas0001038>.

can directly inform medical decisions by providing data relevant to diagnosis, progression or course of conditions, prognosis, and treatment of disorders. In addition, neuropsychological assessments can aid in making accurate predictions about functional abilities across a variety of disorders.^{2,3} Neuropsychological tests are administered in the context of a comprehensive evaluation that synthesizes data from clinical interviews, record review, medical history, and behavioral observations. Where appropriate, these evaluations consider neuroimaging, other neuro-diagnostic studies, and other lab/diagnostic studies to inform neuropsychologically oriented interventions.⁴

Neuropsychological evaluation remains the most sensitive cognitive testing method for discriminating pathophysiological dementia from age-related cognitive decline, cognitive difficulties that are depression-related, and other related disorders, and are the gold standard in both reliably establishing a diagnosis and developing treatment plans by clinically justifying relevant therapies and interventions.⁵ This is important in dementia care, as medications used to treat Alzheimer's disease have virtually no benefit for patients with other forms of dementia. An estimated 17% of Medicare beneficiaries with vascular dementia and 8% with Parkinson's disease are initially misdiagnosed with Alzheimer's disease, resulting in unnecessary treatment costs until they are accurately diagnosed.⁶

CMS stated in the CY 2024 proposed rule, "because the physician/practitioner work RVU is developed based on the time and intensity of the service, the issues regarding the valuation of these types of services are particularly pronounced for services that are billed in time units (like psychotherapy codes) that directly reflect the practitioner time inputs used in developing work RVUs, compared to other services that are not billed in time units in which work RVUs are based on estimates of typical time, usually based on survey data."⁷

As with psychotherapy services and their corresponding codes, all psychological and neuropsychological testing services are time-based services and meet CMS' rationale for the proposed increase in value. We believe that parallel increases in the work RVUs for all psychological and neuropsychological testing and assessment services are warranted to maintain relativity across the current procedural terminology (CPT) codes, and to avoid disincentivizing provision of these services.

Practice Expense (PE) Valuation

As CMS has noted, behavioral health services have very little to no direct expenses, and additionally, clinical psychology has the lowest Indirect Practice Cost Indices (IPCI) of all specialties. CMS has recognized that the methodology used to allocate practice expense RVUs produces an anomaly for services with very low direct practice expense inputs, and that psychologists' services are also disadvantaged under the formula for allocating indirect practice expenses. CMS began to address this issue in 2018 by modestly increasing the indirect PE RVUs for services falling below the indirect PE valuation for a physician office visit.

APA appreciates CMS's alternative methodology and efforts to establish a reasonable minimum value in the allocation of indirect PE RVUs. CMS has made important progress to help ensure beneficiary access to these vital services through review and update of payment policies and continues to request recommendations to systematically address how behavioral health services are valued under the Medicare PFS. However, further adjustments to reimbursement for behavioral health services are needed to shift market dynamics and increase participation, and ultimately to

² Chaytor, N. & Schmitter-Edgecombe, M. (2003). The ecological validity of neuropsychological tests: A review of the literature on everyday cognitive skills. *Neuropsychology Review*, 13, 181–197.

³ Gure, T. R., Kabeto, M. U., Plassman, B. L., Piette, J. D., & Langa, K. M. (2010). Differences in functional impairment across subtypes of dementia. *Journals of Gerontology: Biological Sciences and Medical Sciences*, 65, 434–441.

⁴ Board of Directors. (2007). American Academy of Clinical Neuropsychology (AACN) practice guidelines for neuropsychological assessment and consultation. *The Clinical Neuropsychologist*, 21, 209–231.

⁵ Weintraub S. Neuropsychological Assessment in Dementia Diagnosis. *Continuum* (Minneapolis, Minn.). 2022 Jun 1;28(3):781–799. doi: 10.1212/CON.0000000000001135. PMID: 35678402; PMCID: PMC9492323.

⁶ Hunter CA, Kirson NY, Desai U, Cummings AK, Faries DE, Birnbaum HG. Medical costs of Alzheimer's disease misdiagnosis among US Medicare beneficiaries. *Alzheimer's Dement*. 2015 Aug;11(8):887–95. doi: 10.1016/j.jalz.2015.06.1889. Epub 2015 Jul 21. PMID: 26206626.

⁷ Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. 88 Fed. Reg. 52262. (proposed August 7, 2023).

achieve the CMS Behavioral Health Strategy. APA is urging CMS to close the gap in practice expense valuations between psychologists and other healthcare provider specialties.

It is important for Congress to understand these valuation issues since alternative payment models (APMs) and bundled payments are frequently based upon PFS reimbursement rates.

Supporting Behavioral Health Integration in Alternative Payment Models

In order to effectively respond to the ongoing mental health crisis, it is imperative that new payment models and incentives adequately support integrated primary and behavioral healthcare. Integrated primary care, in which primary care and behavioral health clinicians work together as a team to care for patients and their families, can improve patient outcomes and satisfaction with care and reduce overall treatment costs. It can also increase access to mental health treatment, since as many as 80% of patients with a mental illness visited a primary care provider within the last year, and up to 75% of primary care visits include mental or behavioral health components, including behavioral factors related to chronic disease management and patient health and well-being.^{8,9} In addition to improving the identification and treatment of individuals with behavioral disorders and care of patients' chronic conditions, research shows that integrated care can reduce treatment costs. One study found that integrating a psychologist into a primary care practice resulted in cost savings of \$860 per member per year.¹⁰ We applaud the Committee's approval of the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act, and its provisions in Sec. 104 to support adoption of evidence-based models of integrated care. We urge the Committee to continue to support integrated care in its development of new payment models and policies.

Without a clear and sustained effort to track, report, and make progress on behavioral health, new payment models and value-based payment initiatives risk hindering, not improving, access to behavioral health services. One recent study found that beneficiaries who were assigned to an Accountable Care Organization (ACO) had worse mental health outcomes than those who remained outside ACOs. The authors concluded, "Among patients not enrolled in ACOs at baseline those who newly enrolled in ACOs in the following year were 24% less likely to have their depression or anxiety treated during the year than patients who remained unenrolled in ACOs, and they saw no relative improvement at 12 months in their depression and anxiety symptoms."¹¹ A recent report issued by the Bipartisan Policy Center on integrated primary care concluded:

Payment models, such as CPC+ were intended to incorporate care coordination and behavioral health integration as cost effective means of improving health outcomes. However, these models remain based in Medicare's fee for service structure and lack accountability for behavioral health outcomes and integration. The CMMI Primary Care First model builds on CPC+ and moves practices closer to taking on full risk, while focusing on high need, seriously ill patients. Yet, like CPC+ and Patient Centered Medical Homes, it focuses on physical health rather than behavioral health outcomes. Without adequate quality metrics, there is limited accountability and assessment of the value of integration.¹² (p. 51)

Access to psychological services is critical to the overall success of several CMS Innovation Center model: Innovation in Behavioral Health (IBH) Model; Making Care Primary (MCP) Model; Integrated Care for Kids (InCK) Model; Primary Care First Model Options; Maternal Opioid Misuse (MOM) Model; and Transforming Maternal

⁸ Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). Assessing primary care contributions to behavioral health: a cross-sectional study using medical expenditure panel survey. *Journal of primary care & community health*, 12, 21501327211023871.

⁹ Robinson, P. J., & Reiter, J. T. (2007). *Behavioral consultation and primary care: A guide to integrating services*. New York: Springer.

¹⁰ Ross, K. M., Klein, B., Ferro, K., McQueeney, D. A., Gernon, R., & Miller, B. F. (2019). The cost effectiveness of embedding a behavioral health clinician into an existing primary care practice to facilitate the integration of care: A prospective, case—control program evaluation. *Journal of Clinical Psychology in Medical Settings*, 26, 59–67.

¹¹ Hockenberry, J. M., Wen, H., Druss, B. G., Loux, T., & Johnston, K. J. (2023). No Improvement in Mental Health Treatment or Patient-Reported Outcomes at Medicare ACOs for Depression and Anxiety Disorders: Study examines mental health treatment and patient outcomes at Medicare ACOs. *Health Affairs*, 42(11), 1478–1487.

¹² Hartnett, T., Loud, G., Harris, J., Curtis, M., Hoagland, G. W., Serafini, M., Glassberg, H., Chung, H. (2023). *Strengthening the Integrated Care Workforce*. Bipartisan Policy Center. <https://bipartisanpolicy.org/report/strengthening-the-integrated-care-workforce/>.

Health (TMaH) Model. Integrating behavioral health screening and management services into these models allows more frequent psychological testing to assist with differential diagnosis and treatment recommendations. This is especially important in the classification of severe and persistent mental illness. Identification of these conditions is uniquely important due to high co-morbidity rates, significant negative impacts on mental and physical well-being, and financial burden (*e.g.*, lost income, healthcare spending) associated with the conditions.

To highlight a specific example, neuropsychological testing services will be vitally important to the success of the CMS Innovation Center's Guiding an Improved Dementia Experience (GUIDE) Model, designed to support people living with dementia and their unpaid caregivers. In the GUIDE model, the first recommendation in identifying beneficiaries is to utilize an interdisciplinary approach to the "Initial Comprehensive Assessment Visit," which includes a cognitive assessment. We are also urging CMS to revise the ACO Primary Care Flex model to better incentivize and scale integrated primary and behavioral health treatment, and to establish behavioral health spending reporting requirements to help assess the model's impact on access to behavioral health services.

We appreciate the opportunity to provide comments on this critical issue, and we look forward to working with the committee to establish more effective Medicare payment policies for the benefit of the program's millions of beneficiaries.

Sincerely,

Katherine B. McGuire, MSc
Chief Advocacy Officer

AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS

April 11, 2024

The Honorable Ron Wyden
Chairman
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Mike Crapo
Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Senate Finance Committee Hearing on Bolstering Chronic Care Through Medicare Physician Payment.

Dear Chairman Wyden and Ranking Member Crapo:

We applaud the Senate Finance Committee for examining how to bolster chronic care through the Medicare physician payment. The American Society of Health-System Pharmacists (ASHP) is the largest association of pharmacy professionals in the United States, representing over 60,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies. Our members play a critical role, as part of a comprehensive care team, assisting physicians in their treatment of Medicare beneficiaries suffering from chronic medical conditions. We recommend Congress require the Centers for Medicare & Medicaid Services (CMS) to clearly enable physicians to bill for the entirety of services pharmacists provide incident to the physician.

In inpatient and outpatient settings, pharmacists have traditionally provided team-based clinical services, working collaboratively with physicians, nurses, and other healthcare professionals to enable safe and effective medication. This collaborative approach is necessary because drug therapy is involved in 76% of physician office

visits and is the sole treatment for many acute and chronic conditions.¹ Unfortunately, a 2020 CMS policy change limited physicians to billing only the lowest-level evaluation and management (E/M) code for pharmacist-provided incident-to services, regardless of the duration and complexity of the E/M services provided.² This policy shift undermines care models that enable clinical pharmacists to support physicians and the care teams on which they participate in providing comprehensive care to seniors, thereby threatening patient access to critical services, such as comprehensive medication management. This is particularly worrisome for patients suffering from chronic conditions requiring extensive medication management, such as diabetes, hypertension, or Parkinson's disease.

Problems associated with medication use, such as non-adherence, polypharmacy errors, and adverse events, result in 500,000 emergency room visits and 100,000 hospitalizations yearly, costing the health system over an estimated five billion dollars.³ Pharmacists educate patients and caregivers about their medications, monitor drug therapy, and coordinate communication between patients, insurers, and interdisciplinary specialty providers. Pharmacists' management of medication therapy such as this has been shown to improve transitions of care and reduce hospital readmissions.^{4,5}

In order for it to be financially feasible for care teams to use their pharmacists to provide medication and chronic disease services, ASHP recommends that physicians be allowed to bill for E/M codes for established patients (99211–99215), including when provided by a pharmacist, if the incident-to requirements are met.

ASHP thanks you for your work on this issue. We look forward to continuing to work with you on this issue. If you have questions or if ASHP can assist in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,

Tom Kraus

Vice President, Government Relations

AMERICAN SOCIETY OF PEDIATRIC NEPHROLOGY

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April 25, 2024

The Honorable Ron Wyden
Chair
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Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chair Wyden and Ranking Member Crapo:

On behalf of the American Society of Pediatric Nephrology (ASPN) we appreciate the opportunity to provide this statement for the record on the Senate Finance Committee's April 11th hearing on "Bolstering Chronic Care through Medicare Physician Payment." Pediatric nephrologists serve as the medical home for children with kid-

¹ Budnitz DS, Pollock DA, Weidenbach KN, et al. National surveillance of emergency department visits for outpatient adverse drug events. *JAMA*. 2006;296:1858–1866; *See also* Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug—Related Morbidity and Mortality. *Annals of Pharmacotherapy* 2018, Vol. 52(9) 829–837.

² Centers for Medicare & Medicaid Services, Physician Fee Schedule CY 2021 Final Rule, 85 Fed. Reg. 84592–3 (Dec. 28, 2020), available at <https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf> (Limiting physicians supervising pharmacist-provided incident-to services to billing code 99211 for those services, despite the fact that many of the services provided by pharmacists meet the complexity and duration criteria set forth for code 99212–14).

³ Budnitz DS, Pollock DA, Weidenbach KN, et al. National surveillance of emergency department visits for outpatient adverse drug events. *JAMA*. 2006;296:1858–1866; *See also* Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug—Related Morbidity and Mortality. *Annals of Pharmacotherapy* 2018, Vol. 52(9) 829–837.

⁴ Ni, W., Colayco, D., Hashimoto, J., Komoto, K., Gowda, C., Wearda, B., McCombs, J. Budget Impact Analysis of a Pharmacist Provided Transition of Care Program. *Journal of Managed Care & Specialty Pharmacy*. Feb 2018.

⁵ Budlong, H, Brummel, A, Rhodes, A, Nici, H. Impact of Comprehensive Medication Management on Hospital Readmission Rates. *Population Health Management* 2018. 21(5): 395–400.

ney disease who need specialized care for this chronic condition. We would like to provide input on several of the issues raised during the hearing, including improvements to the Medicare Physician Fee Schedule (MPFS), increasing provider participation in value-based care models, and prior authorization. We also want to raise issues related to Medicaid, as one-third of pediatric patients with end-stage kidney disease (ESKD) are covered by this program.

Founded in 1969, ASPN is a professional society composed of pediatric nephrologists whose goal is to promote optimal care for children with kidney disease and to disseminate advances in the clinical practice and basic science of pediatric nephrology. ASPN currently has over 700 members, making it the voice for pediatric kidney disease. Our members strive to ensure that affected infants, children, adolescents, and young adults receive appropriate and high-quality care. Approximately one third of pediatric patients with ESKD are covered by Medicare, making reforms to the Medicare Access and CHIP Reauthorization Act (MACRA) critical to pediatric nephrologists.

Recommended Changes to the Conversion Factor

Children with end-stage renal disease (ESRD) are automatically eligible for Medicare, and one-third of our patient population has Medicare coverage. Most of the care billed to Medicare falls under the ESRD Prospective Payment System (PPS). However, care delivered to children who receive kidney transplants as part of the Medicare program receive 3 years of post-transplant care under the MPFS, making the stability of the payment system a concern for our members. MACRA provided 0.5% updates to the MPFS conversion factor from 2015–2019. Since then, the lack of statutory updates to the conversion factor combined with the system's budget neutrality requirements has created significant downward pressure on payment.

Children with kidney disease, including those post-transplant, are medically complex and require high levels of care coordination to support their continued growth, development, and health that is not recognized under the MPFS. To support high-quality care for medically complex patients, the Finance Committee must first stabilize the MPFS by providing inflationary updates to the conversion factor and update the budget neutrality factor for the first time since 1992. Once these changes that benefit all physicians are in place, the Finance Committee and the Centers for Medicare & Medicaid Services (CMS) can implement policies to provide incentives to provide high-quality coordinated care.

Increasing Provider Participation in Value-based Payment Models

As discussed, pediatric nephrologists and pediatric ESKD centers serve as the medical home for many children with kidney disease. Since only one-third of children with ESKD have Medicare coverage, the potential for reimbursement for care coordination is low and contributes to the scarcity of pediatric ESRD resources by disincentivizing programs from offering such pediatric care. This reimbursement issue must be addressed both to prevent the loss of existing ESKD resources due to ongoing financial pressures and to allow for consideration of their expansion in a cost-conscious environment. The medical home is particularly important for pediatric ESKD patients, as they also receive hypertension care, which is an important screening for this vulnerable population.

Most pediatric nephrologists practice at children's hospitals. ESKD patients are these institutions only exposure to the Medicare program, which makes participation in value-based programs and models a challenge. To truly incentivize value-based care, quality measures and requirements should be harmonized across payers to reduce confusion and burden. It is also critical that institutions have the staff to be able to participate in data tracking and in reporting measures, which can be difficult for small practices.

The quality programs should be integrated into the existing electronic medical record (EMR) to collect data. There are multiple pain points with silos of care and integrating quality structures into EMRs that need to be addressed. It would also help to increase the number of pediatric measures if they spanned payers beyond Medicare. Measures could look at the entire pediatric ESKD population and better reflect the quality of care.

Recommendations Related to Medicaid Coverage

While the recent hearing did not address the Medicaid program, ASPN urges the Finance Committee to explore improvements to the Medicaid program to improve care coordination and chronic care delivery. As stated earlier, one-third of pediatric ESKD patients are on Medicaid, and so any policy changes must ensure that these patients are able to access the same quality of care as patients on Medicare or pri-

vate insurance. Medicaid reimburses at approximately 80% of the Medicare rate and rates vary across states and services.

Many medically complex children, including those with chronic kidney disease and ESKD, are covered by Medicaid. While covered by Medicaid, medical care supports their growth and development and manages their disease. The program needs to support this complex, coordinated care. Therefore, the solutions that the Finance Committees present should not be limited to Medicare, or we risk creating health disparities based on the patient's insurance coverage.

Recommendations to Improve Prior Authorization

Children and adolescents undergoing dialysis or transplants are unique, and very different from adults. The causes for ESKD in children predominantly include congenital abnormalities, glomerular diseases and rare genetic disorders, not hypertension and diabetes as seen in adults undergoing the same treatment. Children with ESKD also suffer from impaired growth and development, including impaired neurocognitive development. They also have different drug metabolism, which changes over time as they grow to be adults.

These differences between children and adults with kidney disease, and specifically ESKD, are particularly important when considering prior authorization policies, which may delay access to medically appropriate care and therapies for pediatric patients. These children regularly require genetic testing, imaging studies, durable medical equipment, including scales and blood pressure cuffs, 24-hour ambulatory blood pressure monitoring, mental health services, special formulas and feeding tube supplies. All may require prior authorization.

One member reported that prior authorization requirements resulted in a significant delay for a 4-year-old patient suffering from severe hypertension who required CT vascular imaging. When the provider completed the peer-to-peer to complete the prior authorization, the approval delay was because the imaging was to examine the patient's aorta and vasculature rather than the lung parenchyma, which would be examined in adults. Because of the delay, our member considered admitting the child as an inpatient, which would have been at a significantly higher cost to the health care system, to expedite the testing, and ultimately, the necessary treatment. The delay in diagnosis and surgical treatment put the child at risk for stroke and seizure from uncontrolled hypertension. ASPN urges the Finance Committee to consider the unique needs of pediatric ESKD patients when considering prior authorization reforms. Additionally, we recommend that reviewers of prior authorization requests for pediatric patients have pediatric expertise. These vulnerable patients should not experience unnecessary, and potentially dangerous, delays in care because these requirements do not reflect the needs of these children who are commonly covered by Medicare and Medicaid.

Thank you again for the opportunity to submit this statement for the record to the Senate Finance Committee. We look forward to working with the Committee and with the Bipartisan Working Group on Physician Payment reform led by Senators Stabenow and Thune as you develop legislative solutions to improve physician payment and care for patients with chronic conditions. Please reach out to Erika Miller, ASPN's Washington Representative, at emiller@dc-crd.com with any questions or if we can provide additional information.

Sincerely,

Jodi Smith, M.D., MPH
President

AMERICAN SOCIETY OF RETINA SPECIALISTS

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The American Society of Retina Specialists (ASRS) is the largest retina organization in the world, representing over 3,500 board-certified ophthalmologists who have completed fellowship training in the medical and surgical treatment of retinal diseases. The mission of the ASRS is to provide a collegial open forum for education, to advance the understanding and treatment of vitreoretinal diseases, and to enhance the ability of its members to provide the highest quality of patient care.

We appreciate this opportunity to provide input to the committee as it begins its work on reforming and modernizing Medicare physician payment. As physicians who care for a high volume of Medicare beneficiaries with chronic and potentially-blinding eye disease, we are pleased that the committee has begun its work by exploring how best to meet the needs of these patients.

Among our key recommendations for the committee to ensure beneficiaries have continued access to high-quality chronic care are the following:

- Ensure beneficiaries suffering from chronic disease will have continued access to the specialty care they need and physicians receive adequate reimbursement for the care they provide by:
 - establishing regular, inflation-based updates to the Physician Fee Schedule conversion factor, and
 - reforming budget neutrality requirements in the fee schedule to allow for necessary value modifications to existing services, and the adoption of new technologies and treatment protocols without causing unwarranted reductions to other unrelated services.
- Eliminate or modify the Merit-based Incentive Payment System (MIPS) to focus on clinically-relevant measures that address identified gaps in care, particularly to target improving measurement of chronic care services.
- Require the Center for Medicare and Medicaid Innovation (CMMI) to engage with specialists caring for chronic disease patients and work toward implementing alternative payment models (APMs) that address these needs.
- Provide additional funding to physicians and other stakeholders to develop APMs.

Fee Schedule Reform and Modernization

Retina specialists and other physicians are committed to providing the highest quality of care to Medicare beneficiaries with chronic disease. In return, Medicare must provide an adequate and predictable baseline payment level that ensures physicians will have the resources to care for these patients. Two elements of the physician fee schedule—the lack of inflation-based payment updates and outdated budget neutrality limits—are limiting those resources. Thus, practices are having a difficult time staying financially solvent while making necessary long-term investments and meeting growing patient demand. ASRS recommends Congress focus its work on modifying these elements to prevent the need for yearly payment “fixes” and ensure long-term stability.

Inflation-Based Updates

For more than 2 decades, Medicare physician payments have not kept pace with inflation. According to the American Medical Association (AMA), physicians’ purchasing power has eroded by approximately 30% since 2001, while during that time all other Medicare payment systems have realized payment updates that have kept pace with or even surpass the Medical Economic Index (MEI), the chief measure of inflation in healthcare. In fact, the Medicare Physician Fee Schedule is the only payment system without a built-in inflationary adjustment. It is far past time for Congress to act to bring payments in line with current prices and provide assurances that future payment will be adequate. ASRS recommends implementing regular, inflation-based updates to the fee schedule to meet that need.

Budget Neutrality Limits

In addition, Congress must increase the current \$20 million budget neutrality threshold on the Medicare Physician Fee Schedule. It has created unintentional inequities in payment, disrupted the relativity of the fee schedule, and unnecessarily pitted procedural and non-procedural specialists against each other in a fight for value.

As physician services are regularly reviewed by the RUC and CMS, even minor adjustments in a particular service’s value can cause ripple effects across the fee schedule, increasing or decreasing other specialties’ reimbursement without any coordinating change in the services they are providing. Relative value units (RVUs) are painstakingly assigned to account for the unique work and practice expense for each physician service relative to all others. But the annual neutrality adjustments caused by the low threshold are disrupting that balance.

Most concerning is when CMS acts outside of the current relative value system and adds new services to the fee schedule, such as the new E/M add-on code G2211,

which necessitate budget neutrality adjustments. Specifically, G2211 was not valued through the RUC process to maintain relativity in the fee schedule and more accurately gauge the potential utilization of the code. Almost half of the initial 2024 cut to the fee schedule was due to the implementation of this code. It required Congress to act well past the beginning of the year to modify the conversion factor which, unlike prior fixes, was not backdated. As a new and un-tested service, the add-on code should have been phased-in over several years without impacting budget neutrality until its full impact was known. ASRS recommends that Congress increase the dollar threshold that triggers budget neutrality adjustments and empower CMS with authority to override budget neutrality in certain circumstances.

Problems with the fee schedule are borne out in the reimbursement for retina procedures. A 2022 study looked at the trends in reimbursement for 15 procedures commonly performed by retina specialists over 2011 to 2020 and found that the average reimbursement change over that time was a decrease of 8.2%. Adjusted for inflation, the decrease grew to 20.7%.¹ This decline in reimbursement is directly attributable to both the lack of inflationary adjustment and budget neutrality factors that Congress must remedy.

Key Cost Pressures on Retina Specialists' Practices

Retina practices are no different from other physician specialties or other small businesses operating in this period of high inflation. Rising equipment, supply, utility and labor prices are putting retina practices at a disadvantage. In 2023, 84% of U.S.-based retina specialists reported difficulty finding clinical staff for their practices, with 63.5% saying this led to mild or severe understaffing.² Many retina specialists reported losing qualified staff to hospitals or other industries that can afford to pay more competitive wages.

Understaffing is troubling considering how important technicians and administrative staff are in the care of patients with chronic retinal disease. The high prevalence of diseases such as age-related macular degeneration (AMD), diabetic retinopathy, and diabetic macular edema (DME) in the Medicare population coupled with the frequency of necessary visits for these patients—approximately every 4–6 weeks—means that retina practices must run efficiently. Retina specialists rely on their clinical staff to help patients navigate through the process of imaging, exams and preparation for intravitreal injections so the physician can be solely focused on examining the patient, interpreting the imaging, performing the injections and managing the patient's individual care plan. For Medicare Advantage patients and those with commercial insurance, additional administrative staff is needed to deal with the onerous step therapy and prior authorization policies implemented by these payers. Without adequate reimbursement to pay clinical staff, retina specialists may have to reduce their patient load, thereby threatening the vision of patients with potentially-blinding conditions.

While the lack of adequate reimbursement is immediately felt in the day-to-day operations of the practice, payment that does not keep pace with inflation also has a negative long-term impact on patients. Without assurance that payments will keep up, retina specialists are hesitant to expand their practices or invest in new equipment that would allow them to serve patients better. COVID-era delays and increased construction costs have prevented practices from expanding or opening new offices. Declining reimbursement makes it less likely the cost of new clinical or imaging equipment will be recouped.

Like the COVID–19 pandemic, outside influences continue to impact physician practices. Retina specialists have been particularly hard hit by the recent cyberattack on Change Healthcare. This incident has ceased or significantly disrupted reimbursements to retina practices and negatively impacted cashflow—thereby overextending their credit and forcing many to take out loans to purchase the Part B drugs that patients with chronic retinal disease rely on. This single incident demonstrates how fragile the healthcare infrastructure is and underscores that without sufficient physician payment, beneficiaries will lose access to care.

Patient Demand and Administrative Costs Projected to Grow

Evidence suggests that these long-term investments to expand access to care are imperative. The U.S. population will continue to age into chronic retinal disease neces-

¹ Trends in Medicare Reimbursement for Common Vitreoretinal Procedures: 2011–2020. Shriji Patel, MD MBA, et al. Ophthalmology. 2022 Jul;129(7):829–831.

² 2023 ASRS Preferences and Trends Survey, available: https://www.asrs.org/content/documents/_asrs-2023-pat-survey-for-website.pdf.

sitating even more care from retina specialists. A 2022 study found that currently about 20 million Americans over 40 have AMD with about 1.49 million suffering from late-stage AMD³—figures significantly higher than previous estimates. According to the American Diabetes Association, the number of Americans with diabetes is also projected to increase 165%, from 11 million in 2000 to 29 million in 2050—which will likewise increase the number of people suffering from diabetic eye disease who will require care from retina specialists.

However, it is unclear whether those patients will be able to receive the care they need in a timely manner. The projected shortage of primary care physicians is well-documented, however, specialties—including ophthalmology—also face shortages. A 2023 study found that from 2020 to 2035, the supply of U.S. ophthalmologists will decrease relative to demand and lead to a 30% shortfall.⁴ This shortage is already being felt with some retina fellowship programs not being able to fill all available slots. A recent increase in the number of resident slots across medicine was a much-needed first step, but more investment is required to ensure physician supply meets the demand over the coming decades.

As mentioned above, the administration costs associated with MA and other private payers have skyrocketed in the last decade with the rise in utilization management. Care for nearly every non-original Medicare patient with chronic retinal disease is subject to some form of step therapy and/or prior authorization. Retina specialists employ dedicated employees to investigate benefits, determine the specifics of the insurer's step therapy policy, and submit authorizations. While the delay in care and potential poor outcomes for patients are the most concerning aspect of utilization management, the extra labor costs are endangering practices' ability to stay afloat. A 2022 study conducted by ASRS members found that 56.8% of patients experience delays in treatment and practices spend an average of 47 minutes per authorization request, all while 96.3% of prior authorization requests are ultimately approved.⁵ These costs are not associated with original Medicare beneficiaries, but since most private contracts are based on Medicare rates, the additional work required to take care of these patients is not compensated.

Congress needs to take immediate action to tie physician payment to inflation and modify budget neutrality to address the current and future pressures that limit access to care.

Repeal MIPS

At its inception, the MIPS program seemed to include laudable goals, however, it has become clear that Congress should sunset this program. MIPS still functions as four separate and unrelated individual programs that are tedious to implement and do not relate to specialty care. Perhaps the most telling indicator of the program's failure is the lack of evidence to indicate it is improving care. A recent search of PubMed turned up no results of peer-reviewed literature that found a correlation between the MIPS program and improved quality.

CMS' Flawed Implementation of MIPS

At its core, CMS has failed to conceive of and implement MIPS as a unique program that would serve as a bridge between previous disparate reporting programs and new APMs. Each of the categories retains measures and structure from its predecessor and has individual, complex scoring methodologies. Rather than integrating the elements of the programs it replaced, MIPS simply aligns the performance periods and reporting deadlines and combines the scores to translate to one final payment adjustment. CMS' ever-shifting requirements complicate the program and insufficient specialty-specific measures mean retina specialists are typically reporting on primary care measures not meaningful to their practices.

Considering the lack of documented improved outcomes, the significant cost practices incur to participate in MIPS becomes concerning. Infrastructure costs of EHR and hardware are added to the practice staff labor—and oftentimes that of outside consultants—to comply with MIPS. The recent bonus payments of 1–2% associated with MIPS are not significant enough to make the cost to participate worthwhile.

³“Prevalence of Age-Related Macular Degeneration in the U.S. in 2019.” David B. Rein, Ph.D., MPA; John S. Wittenborn, BS; Zeb Burke-Conte, BS; et al; JAMA Ophthalmol. Published online November 3, 2022. doi:10.1001/jamaophthalmol.2022.440.

⁴“Ophthalmology Workforce Projections in the United States, 2020 to 2035.” Sean T. Berkowitz, MD, MBA; Avni P. Finn, MD, MBA; Ravi Parikh, MD, MPH; et al.; Ophthalmology. V.131, Issue 2, p. 133–139, February 2024.

⁵Dang, S. “Anti-VEGF Injection Prior Authorization Impacts on Retina Practices.” 2022 ASRS Annual Meeting, July 16, 2022.

For example, a large retina practice of 21 physicians recently analyzed their cost of participating in MIPS. The practice has two staff members each working about 10 hours per week to oversee the practice's participation in MIPS and found that documenting MIPS for each visit takes about 2 minutes. Added to the direct costs of consultants, the total cost of participating in MIPS is \$13,000 per physician.

Barriers to Specialty-Specific Measure Reporting

Not only is it burdensome for physicians to participate in the program, but CMS largely outsources the creation of measures and infrastructure necessary to run the MIPS program. It relies on the work of non-government entities, such as medical societies, spending considerable resources to enable physicians' participation in the program. In our case, ASRS has acted to address the lack of retina-focused measures by developing three new MIPS quality measures that were implemented for the 2024 performance year. The multi-year process we undertook to develop these measures cost approximately \$335,000, not counting our physicians' uncompensated time, and required multiple attempts to have them accepted by CMS. The physician experts developing these measures felt that the concepts they identified would address gaps in care that were within the power of the individual retina specialist to remedy. While we appreciated feedback from CMS throughout the process, the development was influenced by ensuring that the measures fit within the confines of the program, rather than solely on what was clinically-relevant. Chiefly, we were not able to even draft or test measure concepts around some of the chronic diseases retina specialists treat most frequently, such as AMD and diabetic retinopathy, because it was difficult to identify measurable endpoints for treatments that may last for many years.

The ASRS investment in developing three quality measures pales in comparison to the investment required to establish a qualified clinical data registry (QCDR). The cost to start-up a fully-functional QCDR that includes MIPS reporting is estimated at upwards of \$1 million with additional annual maintenance costs. Unfortunately, some societies that have made this investment have had significant problems. Some established registries, such as those run by the American College of Surgeons and the Society of Thoracic Surgeons, have left the QCDR program because of CMS' onerous programmatic requirements to participate in MIPS, as well as testing and validation criteria. Others have suffered from lack of participation or insufficient return on investment. Even when QCDRs are able to comply with CMS' regulations, the resulting system can be unworkable for practices to use, often forcing them to drop out. These examples show that on top of the cost to participate, MIPS is not only not contributing to improved quality of care, but it may be impeding efforts to collect and analyze clinical data.

Given the lack of evidence that MIPS has improved outcomes, now is the time to repeal MIPS and rethink how to improve quality and value in the Medicare program.

Increase Opportunities and Incentives for Specialty-Focused APMs

CMS did not use any of the money Congress allocated in MACRA to fund grants to specialties to develop APMS. As Congress looks to reform the system, we recommend it make grants available to fund the infrastructure physician organizations need to develop and implement new models. In addition, CMS and CMMI must be required to review physician-submitted models and incorporate specialists' feedback in new models.

Under the current system, no physician-developed model has been implemented by CMS or CMMI, even though MACRA created the Physician-Focused Payment Model Technical Advisory Committee (P-TAC) as a vehicle for physicians to submit their APM concepts. Given this situation many organizations are reluctant to invest time and money in developing new models. P-TAC's website lists dozens of clinician-submitted proposals it has reviewed and made recommendations on to CMS.⁶ However, we are not aware of any such proposal endorsed by P-TAC that has been tested or implemented by CMS to date. After seeing so many other specialty societies and physician groups fail to gain traction with their APM concepts, we are skeptical that CMS would take action on them without further Congressional intervention. Congress must take action to arm the P-TAC with more authority and require CMS to at least test and evaluate the feasibility of recommended models.

⁶Physician-Focused Payment Model Technical Advisory Committee, <https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposals-materials#1081>. Accessed April 18, 2024.

Conclusion

As experts in chronic disease, retina specialists develop strong bonds with their patients over many years. They are focused on customizing each patient's care to help maintain their vision and allow them to continue living independently. The long-term erosion in physician payments, coupled with the rise of administrative burdens and irrelevant pay-for-reporting makes achieving that goal harder every year. We recommend Congress take this opportunity for full-scale reform and invest in the long-term stability of practices providing care to Medicare beneficiaries by implementing inflation-based updates, ameliorating the impact of budget neutrality adjustments, and truly working toward value-based care by removing MIPS and investing in efforts to develop specialty-specific models.

We thank the committee for holding this hearing and appreciate the particular focus on chronic care. We would be happy to provide you with any assistance or additional information you may need. Please contact Allison Madson, vice president of health policy, at allison.madson@asrs.org for assistance.

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April 23, 2024

The Honorable Ron Wyden, Chair
 U.S. Senate
 Committee on Finance
 221 Dirksen Senate Office Building
 Washington, DC 20510

The Honorable Michael Crapo, Ranking Member
 U.S. Senate
 Committee on Finance
 239 Dirksen Senate Office Building
 Washington, DC 20510

RE: Statement for the Record, Hearing on “Bolstering Chronic Care through Medicare Physician Payment”

Dear Chair Wyden and Ranking Member Crapo:

The American Urological Association (AUA) applauds the Senate Finance Committee for holding the recent hearing, *Bolstering Chronic Care through Medicare Physician Payment*. The Medicare program, its sustainability, and its payment policies are of great importance to our members and the Medicare beneficiaries they treat. The AUA commends the Committee for holding this hearing to examine policies to update and strengthen the Medicare program to improve beneficiary access to high-quality care.

The AUA is a globally engaged organization with more than 22,000 physicians, physician assistants, and advanced practice nursing members practicing in more than 100 countries. Our members represent the world's largest collection of expertise and insight into the treatment of urologic disease. Of the total AUA membership, more than 15,000 are based in the United States and provide invaluable support to the urologic community by fostering the highest standards of urologic care through education, research, and the formulation of health policy.

Urologists play a crucial role in the care of patients with both chronic and acute urologic conditions, providing vital services that improve quality of life and often prevent serious complications. Despite the critical nature of urologists' work in enhancing patients' well-being, the existing Medicare reimbursement structure often fails to adequately compensate urologists for the advanced and specialized care they deliver. This discrepancy not only undermines the financial viability of urology practices but also jeopardizes patient access to high-quality care and innovative treatments.

Physician payments have stagnated for the last 2 decades while hospitals and physician practices must continue to pay market rate for supplies, equipment, and staff wages.

For the last several years, Congress has intervened to prevent or mitigate cuts to the Medicare Physician Fee Schedule (MPFS), and the AUA is grateful for these actions. However, our members and the patients they treat deserve better than the unstable and uncertain reimbursement and access environment the annual threat of cuts creates.

The statutory constraints placed on the Centers for Medicare & Medicaid Services (CMS), including the lack of statutory updates and the budget neutrality requirement, limits the agency's ability to stabilize the MPFS and ensure appropriate access to the full range of specialty care without Congressional intervention. To address these constraints and protect Medicare beneficiary access to care, we recommend the following solutions.

Implement Inflationary Updates

According to an American Medical Association (AMA) analysis of Medicare Trustees data, Medicare physician payment has declined by approximately 30% percent when adjusted for inflation from 2001–2024. The MPFS does not receive necessary increases or adjustments for inflation, in contrast to other Medicare fee schedules with the last statutory update of 0.5% implemented in 2019. The decline in reimbursement over the last 2 decades undermines physicians' ability to deliver essential medical services, jeopardizing patient access to timely and high-quality care. **Therefore, AUA recommends Congress provide a statutory update to the MPFS based on the Medicare Economic Index (MEI) to reflect the inflation in practice costs, including but not limited to clinical staff, rent, medical supplies and equipment, and insurance. It is important to note that greater financial stability will lead to improved physician retention ensuring patients have access to timely and high-quality care, and allowed investments in infrastructure, which can contribute to improved efficiency and quality of care delivery.**

Address Budget Neutrality

Current Medicare statute requires changes to the MPFS be implemented in a budget neutral manner, which means that policies that increase or decrease Medicare spending by more than \$20 million require that upward or downward adjustments be made by that excess amount to all physician services. Budget neutrality places unreasonable constraints on MPFS payments and potential policies. **Therefore, AUA recommends that Congress consider raising the budget neutrality threshold from \$20 million to \$53 million to accommodate changes in Medicare spending since this threshold has not been increased since 1992.** This will allow for more flexibility in adjusting physician payments and prevent different specialties from being pitted against one another. Additionally, it will mitigate the dynamic where specialties feel they are pitted against each other when new codes are added to the MPFS or values for existing codes are proposed to be increased. **Congress should also provide for an increase equal to the cumulative increase in the MEI every 5 years to allow this threshold to keep pace with inflation.**

Improving Quality Payment Programs

AUA was pleased that the Committee is interested in improving the Merit-based Incentive Payment System (MIPS) and identifying strategies to bolster more widespread adoption of advanced alternative payment models (APMs). The Medicare Access to CHIP Reauthorization Act (MACRA) authorized the CMS Quality Payment Program (QPP) in to encourage physicians', including specialists like urologists, engagement in innovative healthcare delivery models, fostering a system that rewards improvements in the quality of care delivered. AUA believes that APMs, if implemented well, can incentivize improved quality and better care coordination, which can be especially valuable for conditions like prostate and bladder cancer that may require surgery, radiation, and medical oncology to treat. Unfortunately, MACRA's statutory requirements have impeded Congress' goals for the program and Congress must strive to revise the QPP such that its requirements support the delivery of value-based care and improved quality.

There is a significant administrative burden and financial risk involved with participation in MIPS and APMs. Additionally, the large investment in training takes away time and resources that should be devoted to patient care. In addition, with so many variations in practices, including practice size, specialty type, practice location, and population demographics, a one-size fits all model simply does not work. **To improve the MIPS program, CMS must have the authority and resources to create programs that are meaningful to all providers and patients regardless of specialty type, while lowering the burden to participate in**

these programs. Specialty physicians looking to participate in these programs will find few physician-focused APMs are available for them.

Additionally, CMS has stated its intent to sunset traditional MIPS and move to MIPS Value Pathways (MVPs). The agency is continuing to roll out new pathways each year; however, specialties like urology do not yet have MVP options to participate. While we understand the constraints under the current payment system, we believe that collaboration with stakeholders will assist in creating more meaningful programs and reducing burden for providers.

Additionally, the AUA recommends that quality payment incentives be large enough to cover the costs of the time and resources that are devoted to participating in a quality program while also rewarding physicians for their participation. This is important because it ensures that healthcare providers are adequately compensated for the efforts they put into improving patient care. Not only can financial incentives be used to improve patient care, but this can also be used to provide incentives to urologists and other physicians to practice in underserved areas. **Therefore, Congress must ensure that quality payment incentives are commensurate with the investment of time and resources necessary for sustaining effective quality improvement efforts and ultimately enhancing the quality of care delivered to patients.**

The AUA appreciates your leadership and welcomes the opportunity to work with you to improve Medicare beneficiary access to care and ensure the care delivered by urologists and other physicians is reimbursed equitably. For any questions please contact paymentpolicy@auanet.org.

Sincerely,

Eugene Rhee, M.D., MBA
Chair, Public Policy Council

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Statement of Everett E. Vokes, M.D., FASCO, Board Chair

The Association for Clinical Oncology (ASCO) is pleased to submit this statement for the record of the hearing entitled, “Bolstering Chronic Care through Medicare Physician Payment.” ASCO appreciates the Committee holding today’s hearing to discuss a more sustainable Medicare physician reimbursement system that improves care for beneficiaries, including those with cancer. ASCO is a national organization representing nearly 50,000 physicians and other health care professionals who care for people with cancer. ASCO members are dedicated to conducting research that leads to improved patient outcomes and are also committed to ensuring that evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans, including Medicare beneficiaries.

ASCO supported the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as a replacement for the flawed Sustainable Growth Rate (SGR) formula for Medicare physician reimbursement. Since its enactment, ASCO has provided extensive education to its members as well as significant input to the Centers for Medicare and Medicaid Services (CMS) around necessary refinements to the program to ensure its efficacy in the agency and for Medicare beneficiaries they serve. Unfortunately, physicians still face the same uncertainty MACRA was intended to address—financial instability within the Medicare payment system.

We are encouraged by the Committee’s interest in addressing current challenges and look forward to collaborating on ways to ensure long-term stability in the Medicare payment system. ASCO offers to be an ongoing resource for you as you evaluate the financial sustainability and patient impact of the Medicare physician payment system, MACRA’s effectiveness and the continued transition to a value-based payment system.

ASCO’s History of Quality Improvement

Since its founding over 50 years ago, our affiliate organization, the American Society of Clinical Oncology (the Society), has been dedicated to the delivery of high-quality, high-value care for every patient with cancer—every day, everywhere. The Society

has a wide range of resources and programs aimed at improving the standard of cancer care received by patients in the United States and around the world.

Oncology care is entering a time of unprecedented progress in both the understanding and treatment of cancer. However, today's medical practice environment is facing significant disruption, which threatens oncologists' ability to deliver the high-quality cancer care that patients deserve. Ongoing consolidation of physician practices, escalating cost of care, workforce shortages and physician burnout are on the rise and administrative burden has never been greater. As cancer care professionals navigate these challenges, they are looking for models that enable the delivery of high-quality, high-value cancer care and a framework that supports success regardless of payment arrangements and other administrative policies.

In response to this need,¹ in July 2021, the Society launched its ASCO Patient-Centered Cancer Care Certification initiative. This program promotes the oncology medical home as an effective approach to assuring every patient with cancer achieves the best possible outcome for their disease. It offers oncology group practices and health systems a single set of comprehensive, expert-backed standards for patient-centered care delivery.

The now permanent program (ASCO Certified) is based on Oncology Medical Home (OMH) standards² from the American Society of Clinical Oncology and the Community Oncology Alliance (COA). These standards establish core elements needed to deliver equitable, high-quality cancer care and offer all stakeholders clarity on elements they should expect to see from cancer care teams. The OMH standards focus on seven different domains of cancer care, including patient engagement; availability and access to care; evidence-based medicine; equitable and comprehensive team-based care; quality improvement; goals of care, palliative and end-of-life care discussions; and chemotherapy safety.

The pilot included 95 cancer care sites and nearly 500 oncologists from 12 participating practice groups and health systems in a variety of settings, including community, hospital, and academic settings. Two commercial insurers participated, and others expressed strong interest. Participating practices use the ASCO Quality Reporting Registry (AQRR) for ongoing measurement of quality, outcomes, and utilization measures. Performance data are derived from electronic health records, insurance claims, patient satisfaction surveys, and clinical pathways systems.

Practices meeting the rigorous ASCO–COA Oncology Medical Home Standards are certified by the ASCO Certification Program. Certified practices are expected to sustain adherence to the ASCO–COA OMH standards demonstrated through ongoing assessment and improvement activities monitored and evaluated by the ASCO Certification Program.

Additionally, ASCO's Quality Oncology Practice Initiative (QOPI®) Certification Program³ provides a three-year certification recognizing high-quality care for outpatient hematology-oncology practices within the United States and certain other countries. Its primary focus is the safe delivery of chemotherapy in the outpatient setting. Practices receive QOPI Certification based on their full compliance with QOPI Certification Standards as assessed during an on-site survey.

Enhancing Oncology Model

In June 2022, the Center for Medicare and Medicaid Innovation (CMMI) announced a new, 5-year voluntary oncology payment model, the Enhancing Oncology Model (EOM),⁴ which began on July 1, 2023. Participating oncology practices are taking on financial and performance accountability for episodes of care surrounding systemic chemotherapy administration to patients with seven common cancer types: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer. EOM participants are responsible for the total cost of care during a 6-month episode and elect to participate in one of two, two-sided financial risk arrangements.

EOM employs specific design elements, including comprehensive, coordinated cancer care; data-driven continuous improvement; payment incentives, including a Monthly Enhanced Oncology Services (MEOS) payment and a performance-based payment (PBP) or a performance-based recoupment (PBR); an aligned multi-payer structure; and focused efforts to identify and address health disparities.

¹ <https://practice.asco.org/quality-improvement/quality-programs/asco-certified>.

² <https://ascopubs.org/doi/full/10.1200/OP.21.00167>.

³ <https://practice.asco.org/quality-improvement/quality-programs/qopi-certification-program>.

⁴ <https://www.cms.gov/priorities/innovation/innovation-models/enhancing-oncology-model>.

EOM participants are required to implement participant redesign activities, including 24/7 access to care, patient navigation, care planning, use of evidence-based guidelines, use of electronic Patient Reported Outcomes (ePROs), screening for health-related social needs, use of data for quality improvement, and use of certified electronic health record technology. As part of the data reporting for quality improvement, EOM participants will submit health equity plans to CMS, where participants detail evidence-based strategies to mitigate health disparities identified within their beneficiary populations.

ASCO is pleased that EOM is a voluntary model and that practices were able to choose to participate based on their level of readiness and ability to assume financial risk. We fully support CMMI's focus on equity and coordinated cancer care. The cancer care delivery requirements of the CMMI EOM have many similarities with ASCO–COA Oncology Medical Home Standards and ASCO Certified. Practices achieving ASCO Patient Centered Cancer Care Certification will be well positioned to succeed in the EOM.

We are concerned, however, that CMMI significantly reduced MEOS payments compared to similar payments in the earlier Oncology Care Model (OCM). This is especially concerning given that there was a 1-year gap between the end of OCM and the start of EOM, during which time practices received no additional support for the mechanisms instituted during OCM to enhance patient access and care coordination that are continuing under EOM. The limited MEOS may not cover the practice redesign efforts needed in this model with financial risk.

While OCM prompted practice changes that enhanced patient-centered care, those changes cannot be sustained or broadened to other practices without a regulatory and payment framework that supports them. We are eager to work with CMS and Congress to enable the practice transformation critical to practices surviving and thriving in the years ahead, so patients receive the care they need and deserve.

Below are areas of improvement we believe are vital to achieving high-value, high-quality care for all patients with cancer.

Medicare Physician Payment Reform

In repealing the SGR, MACRA specified a 0% update to the Medicare Physician Fee Schedule (MPFS) Conversion Factor (CF) for a period of 6 years, followed by a 0.25% annual increase for Merit Based Incentive Payments System (MIPS) participants and a 0.75% annual increase for Advanced Alternative Payment Model (APM) participants thereafter. While Congress provided temporary relief in 2021 and 2022, physician reimbursement was cut in 2023 and again in 2024. In the Consolidated Appropriations Act of 2024, passed on March 9, 2024, Congress included a +1.68% adjustment to the MPFS CF for the remainder of 2024. This increase resulted in a 1.68% reduction to the 3.37% CF. This did not apply retroactively, with claims with dates of service prior to March 9 reimbursed using the original conversion factor.

Failure of the MPFS to keep up with increasing labor, supplies, rent, and other practice expenses influences a growing site-of-service shift from independent physician practices to off-campus outpatient hospital departments paid for by the Outpatient Prospective Payment System (OPPS). Rather than addressing the lack of sufficient payment under the MPFS, Congress directed CMS to reduce payments to new off-campus outpatient hospital departments, thereby encouraging further shifts into on-campus departments. Instead of encouraging value-based care, this consolidation results in reduced beneficiary access to community-based healthcare services. Congress must ensure that future payment updates within the MPFS are sufficient to sustain beneficiary access to community-based physician care.

While we appreciate Congress' efforts to help stabilize physician payment, ASCO hopes to see a longer-term solution. We strongly support and encourage lawmakers to support the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474), not yet introduced in the Senate. This legislation aims to provide an annual update to a single conversion factor under the MPFS that is based on the Medicare Economic Index (MEI). This inflationary increase will help providers keep up with rising healthcare costs. Moreover, ASCO supports the *Providing Relief and Stability for Medicare Patients Act of 2023* (H.R. 3674) and the *Provider Reimbursement Stability Act of 2023* (H.R. 6371), legislation that would increase resources across all Medicare service codes. Following the initial increase, the fee schedule would see annual adjustments based on the MEI. ASCO appreciates the inclusion of the provision to update direct costs associated with practice expense relative value units (RVUs) once every 5 years. Lastly, both bills would address over- and under-utiliza-

tion estimates, which impacts budget neutrality in the MFPS. These consistent investments in Medicare services are crucial to the vitality of our profession and the quality of care we provide.

MIPS Budget Neutrality and the Exceptional Performance Bonus

For performance year 2021, there were a total of 954,664 MIPS-eligible clinicians under the Quality Payment Program (QPP) MIPS track.⁶ Of that total number, 951,744 (99.7%) avoided a negative payment adjustment. Almost 84% achieved exceptional performance and earned positive payment adjustments ranging from +0.09% to +1.79%. Only those clinicians scoring high enough to earn an exceptional performance bonus actually received any positive payment adjustment. Clinicians who received a positive score, but did not reach the exceptional threshold, received a payment adjustment of 0% due to the budget neutrality requirement of MIPS as established by MACRA (*i.e.*, absent the “exceptional performance” bonus, the number of negative adjustments equals the number of positive adjustments). As only 0.31% of clinicians received a score below the threshold (and received a 7% penalty), the only real source for a positive payment adjustment came from the \$500 million annual “exceptional performance” bonus. With the sunset of the ability to earn this bonus in performance year 2022, it is very likely that high-scoring clinicians participating in MIPS going forward will receive little to no positive adjustment through MIPS; this is compounded by the 0% statutory update to the MIPS track until 2026 and the lack of an inflationary update to the MFPS.

When the MIPS track of the QPP was originally envisioned, it was thought that a budget-neutral system would provide rewards to high performers, while penalizing low performers. Experience has shown us that small and rural practices disproportionately bear the burden of growing penalties, which in the aggregate are far too small to result in any meaningful distribution to higher performers. The budget-neutral nature of MIPS should be re-examined, as should the exceptional performance bonus. We urge the Subcommittee to consider legislation to not only address budget neutrality in the MFPS as outlined above but also in MIPS.

Provider Participation in APMs

MACRA provided for a time-limited, annual payment incentive to Qualifying APM Participants (QPs) equal to 5% of estimated aggregate payment amounts for covered professional services. The incentive payment was intended to encourage participation in advanced APMs and has been critical in assisting physicians to develop the infrastructure necessary for the transition to value-based payment models.

Unfortunately, the combination of a lack of specialty-specific advanced APMs, financial uncertainty throughout the COVID-19 pandemic, and delays in the rollout of certain APMs (*e.g.*, Oncology Care First, now named Enhancing Oncology Model) has resulted in many physicians being unable to qualify for this incentive. The payment incentive for advanced APMs was extended by 1.8% under the Consolidated Appropriations Act of 2024. While we appreciate Congress’ efforts to ensure providers can successfully participate in value-based payment models in the short term, longer-term solutions are necessary to address the incentive gap we are nearing. Specifically, we encourage Congressional support for S. 3503/H.R. 5013 the *Value in Health Care Act of 2023 to extend incentive payments for eligible APMs for an additional 2 years*. Additionally, Congress should consider long-term solutions, beyond the 5-year cap outlined in the legislation to ensure financial stability in the program.

Further, to qualify for the APM incentive, physicians must meet either the Medicare Payment Threshold Option or Medicare Patient Threshold Option. These thresholds are meant to ensure that physicians meaningfully participate in alternative payment models. Many specialty physicians will find it difficult to qualify under the currently specified thresholds. For example, oncologists who participate in a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) naturally have lower payment and patient threshold scores due to receiving referrals from primary care physicians outside of the ACO. As a result, many ACOs are considering whether to remove specialists from their participating physician lists so that the remaining physicians may be deemed QPs.

Even within specialty-specific models, specialists may find that the limited scope of models—the EOM includes only seven cancer types—makes it difficult to meet the specified thresholds. Congress should extend the current 50% payment threshold and 35% patient threshold and should also direct CMS to remove barriers to participation in multiple APMs, such as allowing a single practice (identified by a Tax Identification Number) to participate in multiple ACOs.

Conclusion

Thank you for your commitment to improving the Medicare program and cancer care delivery. ASCO stands ready to serve as a resource as you continue this much needed dialogue around reforms to the physician reimbursement system. Please contact Kristine Rufener at Kristine.Rufener@asco.org with any questions.

LETTER SUBMITTED BY A. JOSEPH BORELLI, JR., M.D.

April 11, 2024

Senator Ron Wyden
Chairman
U.S. Senate
Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

Senator Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Subject: Revision of Medicare MRI Reimbursement Rates

Dear Chairman Wyden and Ranking Member Crapo,

Please accept this statement for the record regarding the U.S. Senate Finance Committee Hearing titled *Bolstering Chronic Care through Medicare Physician Payment on April 11, 2024*. Having served as the former Chair of the Committee on MRI Accreditation for the American College of Radiology, which established the MR Accreditation Program in 2011—a program now integral to CMS's efforts to guarantee the quality and safety of MRI procedures to our seniors nationwide—I possess an in-depth understanding of the financial and operational challenges that MRI facilities encounter. This is particularly true for facilities like ours, operating in non-hospital, freestanding settings and serving a high volume of Medicare beneficiaries.

Our current Medicare reimbursement structure does not adequately accommodate the operational costs of MRI facilities, especially those like ours that incur about \$100,000 per month in fixed costs, including the lease and maintenance of a modern 3T MRI scanner of about \$35,000 per month. The cost of providing healthcare insurance for our employees has increased by 50% in the last 7 years, while Medicare reimbursement has been repeatedly cut. Currently, the typical technical reimbursement rate of approximately \$100 per MRI procedure is insufficient to cover these expenses given the capacity limitations of MRI scanners, which typically perform about 300–500 scans per month. Hospitals, on the other hand, are reimbursed at nearly twice that amount.

To address these challenges, I propose two key budget-neutral adjustments to the Medicare MRI reimbursement rates for independent, non-hospital-affiliated facilities:

1. **Equipment-Based Reimbursement Scale:** Establish a committee to annually adjust reimbursements in a budget-neutral manner based on the resale value of MRI equipment. This would ensure that facilities using higher-quality equipment receive a reimbursement rate that reflects their greater diagnostic capabilities and higher operational costs, while facilities with lesser equipment receive correspondingly adjusted rates. This would also eliminate the financial incentive to purchase the cheapest available equipment in the self-referred setting (*e.g.*, orthopedic offices).
2. **Geographic and Demographic Considerations:** Implement adjustments for facilities in regions with a high proportion of Medicare beneficiaries, like Beaufort County, South Carolina, where 75% of our patients are seniors. This would help facilities in high-demand areas maintain a high standard of care without financial strain. Regions with a lower proportion of Medicare beneficiaries would see reduced reimbursement, to maintain budget neutrality.

These proposals aim to create a more equitable and sustainable reimbursement model that reflects both the quality of diagnostic equipment and the demographic

realities of different regions. My extensive experience in developing MRI accreditation standards informs these recommendations, emphasizing a commitment to the quality, safety, and sustainability of diagnostic imaging services.

I am eager to collaborate with your committee to refine and implement these proposals. Thank you for considering these urgent adjustments, and I look forward to your partnership in enhancing healthcare services for our senior population.

Sincerely,

A. Joseph Borelli, Jr., M.D.
Former Chair
Committee on MRI Accreditation
American College of Radiology

President and Medical Director
3T MRI at Belfair

COALITION OF STATE RHEUMATOLOGY ORGANIZATIONS

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CSRO is comprised of over 40 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist. We thank the Committee for its bipartisan interest in the topic of physician reimbursement. We offer several initial ideas for reform herein and would welcome the opportunity to discuss these in more detail.

Rheumatologic disease is systemic and incurable, but innovations in medicine over the last several decades—primarily the development of biologics and biosimilars—have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life. However, rheumatoid arthritis (RA) and other autoimmune conditions are extremely complex. Although rheumatology is beginning to benefit from more precise diagnostics, we still cannot predict with absolute accuracy which medication will work for a particular patient, because of RA's varied signaling pathways. Even where these tools are available, developing value-based care metrics or episode-based measures remains difficult. Within the confines created by these challenges, CSRO nonetheless continues to engage in efforts to define episodic care and appropriate cost measures.

For rheumatology and every other Medicare-heavy specialty, a major barrier to the exploration of additional value-based care initiatives is reimbursement instability in the Medicare Physician Fee Schedule and its downstream effects on reimbursements from Medicare Advantage plans. Practices with high numbers of Medicare beneficiaries are faced with a large and growing gap between their reimbursement and their costs, which leaves little to no room to invest in the systems and infrastructure that modern medicine demands or to incur the financial risk that many value-driven models require. For that reason, we urge the Committee to focus congressional efforts on five policy areas that will provide immediate and long-term stability to the Fee Schedule, as described below.

I. Inflation Update

Unlike all other major Medicare payment systems, the Fee Schedule lacks a mechanism to incorporate inflationary increases into its reimbursement rates. That has created an ever-growing disconnect between the cost of providing care to Medicare beneficiaries and the program's reimbursement for that care. The medical community's endorsement of the Medicare Access and CHIP Reauthorization Act (MACRA) was rooted in the belief that it would replace the unpredictable Medicare payment landscape with a stable, quality-rewarding system. Unfortunately, this shift has not materialized as anticipated. According to the American Medical Association, reimbursement for Medicare physicians declined by 26% from 2001 to 2023, when one adjusts for inflation in practice costs. That is not a sustainable payment system and, inevitably, will lead to beneficiaries experiencing difficulty finding physicians who accept Medicare.

The bipartisan Strengthening Medicare for Patients and Providers Act (H.R. 2474) would provide an annual Fee Schedule update based on the Medicare Economic Index (MEI), which is the most relevant inflation metric for medical practices. CSRO urges the Congress to enact this legislation.

II. Budget Neutrality

The Fee Schedule is subject to a statutory budget neutrality requirement, whereby increases in spending over a certain threshold must be offset by equivalent reductions in spending that same year. That threshold is \$20 million, a level set by Congress in 1992 and never updated since. The Centers for Medicare and Medicaid Services (CMS) has no authority to change this statutory requirement, though its policy decisions have in the past “triggered” the threshold, thereby resulting in commensurate reimbursement reductions across the Fee Schedule. The concept of budget neutrality has turned the Fee Schedule into a fixed pie, while the outdated threshold amount will result in the threshold being triggered more and more as time goes by. The budget neutrality requirement is a main contributor to the annual pattern of Congress averting or mitigating reimbursement reductions at the last minute.

CSRO urges the Congress to enact Section 5 of the bipartisan Physician Fee Schedule Update and Improvements Act (H.R. 6545), which would update the budget neutrality threshold to \$53 million and establish inflationary indexing on a 5-year basis from there.

III. Practice Expense Data Input Updates

In 2022, CMS updated clinical labor practice expense (PE) inputs for the first time in two decades. Although that was a welcome update, the long delay meant that large increases were necessary to reflect twenty years of wage growth. That in turn triggered budget neutrality reductions once implemented.

As part of long-term Fee Schedule stabilization, CMS must be directed to update data inputs on a more frequent and regular basis. ***CSRO urges the Congress to enact section 6 of the legislation mentioned above (H.R. 6545), which would require CMS to update direct costs to calculate PE RVUs every five years at a minimum.***

IV. Stop Extensions of Medicare Sequestration

After a temporary reprieve during the public health emergency, the 2% Medicare sequestration was fully phased back in as of July 1, 2022. When the Medicare sequester was first created, it was scheduled to occur from FY 2013 through FY 2021. However, Congress has since extended Medicare sequestration to pay for other priorities, so that it currently extends through FY 2032—a full decade past its originally envisioned end date. Extending the Medicare sequester to offset new spending exacerbates the long-term underfunding of the Fee Schedule. ***We urge Congress to reject any further extensions of the Medicare sequester.***

V. Unique Situation of Buy-and-Bill Part B Clinicians

The new Medicare Drug Price Negotiation Program (MDPNP) will become fully applicable to the pricing of selected Part B drugs in 2028, which is expected to result in large reductions to average sales prices (ASPs) for the selected medications. That in turn will result in reductions to reimbursement for the physicians who buy these medications at-risk for in-office administration, because reimbursement for selected drugs would be based on the maximum fair price (MFP) established via the MDPNP plus 6%, instead of the current ASP plus 6%. (Note that, in either scenario, the reimbursement amount would be subject to the 2% Medicare sequester.)

In the legislative process leading up to enactment of the MDPNP, several provider groups expressed concern that this program could have unintended consequences on the financial stability of practices who acquire medication for in-office administration. The legislation tried to guarantee the MFP price point for provider acquisition, but that guarantee will be difficult to operationalize in the complex world of drug acquisition, which features several layers of middlemen. If MFP-based reimbursement drops below acquisition costs for selected drugs, medical practices will suffer financial instability and may have to stop offering the selected drugs until acquisition costs can meet reimbursement levels. There is also a lack of clarity on the extent of the impact that MFPs will have on commercial ASPs and on the additional administrative burden that practices will have to incur to manage the different reimbursement rates for the same medication.

For these reasons, ***CSRO urges you to include the Protecting Patient Access to Cancer and Complex Therapies Act (S. 2764/H.R. 5391) as part of com-***

prehensive physician payment reform. That legislation would leave intact the MDPNP process, but would make changes to the mechanics of how Medicare obtains its savings. More specifically, the bill would remove Part B providers from the middle by requiring the drug manufacturers of selected drugs to reimburse Medicare directly for the difference between ASP and MFP on their selected products. Notably, the bill keeps intact the two major goals of the MDPNP: Medicare would still obtain significant savings on Part B drugs and the bill would still guarantee beneficiaries access to MFP-based cost-sharing. This “best of both worlds” approach would keep in place the benefits of the MDPNP yet would also ensure that Part B providers are not inadvertently harmed in the process, ultimately protecting their Medicare patients’ access to needed medication in the lowest-cost site of care.

Thank you again for holding a hearing on Medicare physician reimbursement and for affording stakeholders the opportunity to provide input for the record. If you need additional information, please don’t hesitate to contact us.

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April 24, 2024

Chairman Ron Wyden
U.S. Senate
Committee on Finance
Washington, DC 20510

Ranking Member Mike Crapo
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The College of American Pathologists (CAP) appreciates the opportunity to share our views with the Senate Finance Committee regarding chronic care and the Medicare Physician Payment System. As the world’s largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the College of American Pathologists (CAP) serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

As you are aware, pathologists are physicians who specialize in the diagnosis of disease. On any given day, pathologists impact nearly all aspects of patient care, from diagnosing cancer to managing chronic diseases such as diabetes through accurate laboratory testing. Often, they guide primary care and other doctors, determining the right test, at the right time, for the right patient. Pathologists in hospitals and independent laboratories around the country are also responsible for developing and/or selecting new test methodologies, validating, and approving testing for patient use, and expanding the testing capabilities of the communities they serve to meet emergent needs. Pathologists assure compliance with laboratory regulatory and accreditation standards, while preventing overuse or improper application of tests. Although patients may never meet the pathologist on their care team, they can be assured that these experts deliver quality and care at every step. Indeed, the influence of pathology services on clinical decision-making is pervasive and constitutes a critical infrastructure and foundation of appropriate care.

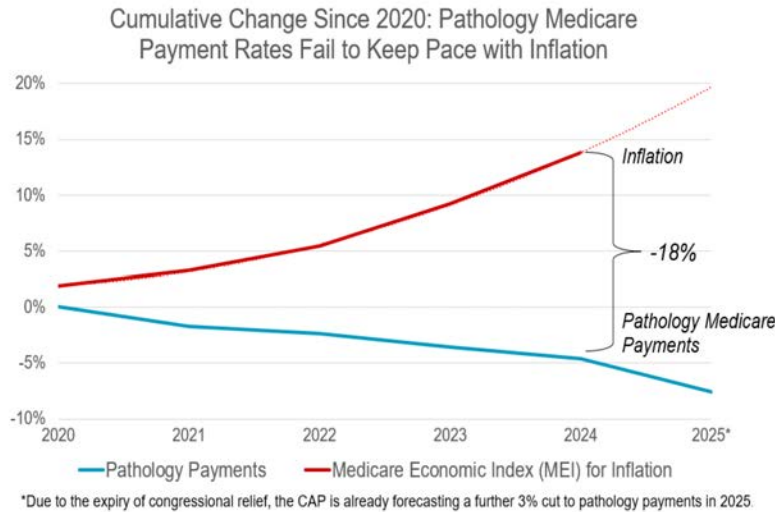
To help bolster the provision of chronic care services, the CAP recommends Congress work to stabilize the physician payment system, grow the health care workforce, increase oversight of insurer-imposed policies that impact patient care, and look at meaningful sources of health spending.

Sustainable Provider Financing

Inflationary Update

Over the last 5 years payments to pathologists have decreased by approximately 4.6 percent, while physician practice costs (medical supplies, lab personnel costs, professional liability insurance) have increased by nearly 13.8 percent. In 2024 alone, pathologists are anticipated to experience a net 5.7 percent reduction in Medicare Physician Fee Schedule reimbursement as payments are expected to fall by close to 1.1 percent while expenses are expected to increase by over 4.6 percent. The lack of an annual inflationary update for pathologists, especially those that operate small businesses, compounds the wide range of shifting economic factors impacting the practice of pathology, such as increasing administrative burdens, staff salaries, office

rent, and purchasing of essential technology when determining their ability to provide care to Medicare patients. The absence of an annual inflationary update, combined with the Physician Fee Schedule's statutory budget neutrality requirements and ongoing Medicare payment cuts, further compounds the difficulties pathologists face in managing resources to continue caring for patients in their communities. **Therefore, the CAP requests that the Committee pass legislation to provide an inflationary update to the Medicare Physician Fee Schedule.**



	2020	2021	2022	2023	2024	5-Year Total	Yearly Average
Pathology Medicare Payments	0.03%	-1.75%	-0.65%	-1.16%	-1.11%	-4.64%	-0.93%
Medicare Economic Index (MEI) for Inflation	1.9%	1.4%	2.1%	3.8%	4.6%	13.80%	2.76%
Difference	-1.87%	-3.15%	-2.75%	-4.96%	-5.7%	-18.44%	-3.69%

Since 2020, reimbursement rates for pathology services have gone down by approximately 4.6%, while physician practice costs (medical supplies, lab personnel, professional liability insurance) have increased by nearly 13.8% over the same timeframe. In 2024 alone, pathologists are anticipated a net 5.7% reduction in Medicare Physician Fee Schedule reimbursement as payments are expected to fall by 1.1% while costs are expected to rise by 4.6%. Currently, it is too early to predict an MEI for 2025. Therefore, it is not included in above chart.

Budget Neutrality

Budget neutrality is another barrier to achieving high-quality, high-value health care. These requirements lead to arbitrary reductions in reimbursement unrelated to the cost of providing care, forcing physicians and other health care providers into adversarial roles, leading to an unpredictable reimbursement system from year to year. The CAP acknowledges that budget neutrality is a politically appealing option to control rising health care costs. However, the CAP urges Congress to think more creatively and expansively about ways to manage health care costs which do not generate such significant instability for health care providers, threatening beneficiary access to essential health care services.

Because of the continuous reimbursement cuts caused by the Physician Fee Schedule's budget neutrality requirements and the lack of an inflationary update, the cost of providing patient care is becoming unsustainable. As costs exceed revenues, laboratory workforce shortages will worsen. The result: increased wait times in the

emergency department, longer time before receiving a diagnosis of cancer, potential for increased errors in testing and delays in specimen collection and turnaround time for laboratory results. **Therefore, the CAP requests that the Committee pass legislation to eliminate, revise, or replace the budget neutrality requirements in Medicare.**

Effectiveness of MACRA

MACRA was originally passed to end a cycle of Medicare payment cuts and reward value-based care, yet today we are faced with continued financial instability within the Medicare physician payment system and value-based care that is not incentivized or attainable for most physicians.

There has been a chorus of dissatisfaction with the Merit-based Incentive Payment System (MIPS). The Medicare Payment Advisory Commission (MedPAC) has questioned the value of the MIPS program due to its design and measurement methods. Indeed, the Government Accounting Office's (GAO) 2021 report on *Provider Performance and Experiences under the Merit-based Incentive Payment System* described many of the challenges physicians experience in the MIPS program, including the question of whether MIPS meaningfully improved quality of care or patient outcomes. It further indicated that the design of the program may incentivize reporting over quality improvement. CMS's response to the GAO report was that a new pathway in MIPS, called MIPS Value Pathways (MVPs) would address many of these challenges. Unfortunately, both the MIPS and MVP quality programs continue to pose challenges, including for the care of chronic conditions. Alternative payment models (APMs) have similar issues, while the burden of data entry and other administrative requirements continue to impede the effectiveness of MACRA instead of improving care for patients.

1. Quality Programs

The MIPS and MVP programs incentivize silos of care rather than rewarding integration of the care team. Because CMS scores individual clinicians on quality measures that apply only to individuals, there is no incentive to foster collaboration. The proposed future of MIPS, MIPS Value Pathways or MVPs, exacerbate this problem because most current and proposed MVPs are specialty-specific rather than condition or procedure-specific. For instance, instead of a Melanoma MVP that includes quality measures for the entire care team (primary care clinicians, pathologists, dermatologists, Mohs' surgeons, etc.), the Dermatological Care MVP includes quality measures for a variety of unrelated dermatological conditions. Thus, only dermatologists are eligible for this MVP and the disparate quality measures within it do not incentivize collaboration among dermatologists.

This problem is even worse for patients with chronic conditions who may require ongoing and episodic care; integration among the care team is even more important for these beneficiaries. However, the MIPS program only permits quality measures that cover a single calendar year, which does not align with how patients with chronic conditions experience care.

CMS should not remove or disincentivize process measures, especially for patients with chronic conditions. Since outcomes may be few and far between for these patients (*e.g.*, diabetes will never be fully resolved for a patient), process measures are critical to ensure patients are receiving appropriate ongoing care. While we understand CMS' desire to measure outcomes, under the belief that is what matters most to patients, for chronic conditions especially, process measures are critical.

Further, the CMS-proposed "upsides" of MIPS participation have not materialized, even for the highest performers. The seemingly promised 9 percent potential positive payment adjustments in return for flat PFS have not been realized and the cost and burden of participation in MIPS has been higher than anticipated. Thus, within MIPS, the administrative and financial burden of participating far outweighs any marginal improvements in cost and quality that could possibly be ascribed to MIPS participation.

2. Advanced Alternative Payment Model (APM)

Within the APM track, there is an equivalent lack of meaningful results, with increased and unnecessary complexity built into the system. CMS recently acknowledged in its own *Synthesis of Evaluation Results across 21*

Medicare Models, 2012–2020 that most of the current models created by the Center for Medicare and Medicaid Innovation (CMMI) are not meeting quality and savings goals. In fact, according to the CMS report only two APMs on CMS's list of 21 improved the patient experience of care.

Additionally, despite there being hundreds of APMs, there have been very limited options for physicians to participate, much less for them to receive Qualifying APM Participant status from meeting the Advanced APM participation threshold. Per the recently released MedPAC data book (July 2022), most clinicians participating in Advanced APMs were in accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP). In fact, of the clinicians who qualified for the 5 percent Advanced APM bonus, over 75 percent were in MSSP. Four other Advanced APMs made up most of the rest of the eligible clinicians, while just 3.4 percent participated in an Advanced APM other than the top four or MSSP. One look at the CMS website for available APMs, their associated rules, dates for sign-up, data reporting and other requirements, demonstrates an extraordinary amount of complexity for models that are hardly being utilized.

Further, many single-specialty practices are disenfranchised from being able to participate in APMs altogether. As currently envisioned by the CMS, APMs significantly favor multispecialty practices, including larger systems in urban settings. And while the CMS wants to see all Medicare beneficiaries and most Medicaid beneficiaries enrolled in an accountable care relationship by 2030, it is unclear how single-specialty, community-based practices can effectively participate in CMS's vision. The CMS has not explicitly articulated how this transition will occur, nor what they see as the primary accountable care relationship model for specialists. The CMS has acknowledged broad concerns among participants that the path to APMs remains unclear, particularly for specialties other than primary care. For example, of the Advanced APMs currently available, we believe pathologists are only able to participate in at most three models, and only to a very limited extent. Clearly, more opportunities are needed for specialty physicians to participate in Advanced APMs and incentives must recognize that high-value care is provided by both small practices and large systems, in both rural and urban settings.

3. Reduce Health IT Administrative Burdens

Another major barrier concerning implementation of MACRA is the associated administrative burden, particularly as it relates to the current state of health care data. While electronic health records are critical for advancing care accuracy, speed, and coordination, one size does not fit all with respect to health information technology (health IT). Even within a single specialty, different physician practices may have different levels of fluency with technology, and between specialties, maturity of health IT can vary widely. Therefore, when it comes to implementing the requirements of a system-wide program like MACRA, we suggest that regulations should acknowledge the varying states of data and encourage flexibility to accommodate different health IT readiness. Furthermore, rather than impose health IT requirements across the board, CMS and other agencies should work with stakeholders to move from the current state to an improved future state that promotes greater health data interoperability.

Data entry remains a major burden to complete implementation of MACRA, as it requires significant time and effort on the part of physicians and/or administrative staff, an average of more than 200 hours a year in one study.¹ However, one proposed alternative is quality measurement based on administrative claims. While these measures reduce data entry burden, they do not represent a complete fix; downsides of administrative-claims-based measurement include limited available data, retrospective evaluation, and oftentimes limited clinician control over the processes being measured. The CMS acknowledges the need for real-time evaluation

¹Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum*. 2021;2(5):e210527.

and feedback, which cannot be accomplished with administrative-claims-based measurement.

The underlying PFS has created significant financial instability for physician practices, and dissatisfaction with MACRA may further discourage participation in value-based care models in the future. The long-term consequence of failing to avert the cuts and improve the effectiveness of MACRA is decreased patient access to care. The CAP urges the Committee to improve the provision of chronic care services to patients by minimizing physician administrative, financial, and technological burdens of participation in MACRA. To further improve the effectiveness of MACRA and provision of chronic care, the CAP asks the committee to take the following actions:

1. *Pass legislation to maintain meaningful quality measures.* The CMS is attempting to replace process measures: measures that look at whether the clinician did what he or she was supposed to do (example: annual hepatitis screening for active drug users) with outcome measures: what was the outcome of the procedure (example: decrease in lower back pain). This is an issue for pathologists because there are not relevant outcome measures for pathology. Pathologists do not have direct attributable control over the outcome of most procedures. Process measures have been and remain very important in all aspects of health care and efforts should be taken to protect them.
2. *Pass legislation to improve stakeholder participation in the development of new payment models.* The CAP remains concerned that models are being developed by CMMI that dramatically change providers' clinical decision-making without considering the input of those specialties impacted by the model. Thus, the CAP has sought to ensure physicians, especially the societies that represent physicians participating in and affected by new payment models, have input into new model development. Specifically, in carrying out its statutory duties of testing innovative health care payment and delivery models that lower costs while "preserving or enhancing the quality of care," CMMI is required to consult clinical and analytical experts with expertise in medicine and health care management. Amongst those clinical experts and those with expertise in medicine and health care management, CMMI should be required to include associations representing physician specialties whose services are impacted directly in both primary and supporting roles by the Center's models. Consultation with specialty associations will help ensure that models developed in a manner that is transparent and focused on the best interests of the patient consistent with sound clinical input and practices.

Additionally, the fact that CMS has yet to take up any of the models recommended by the Physician Focused Payment Model Technical Advisory Committee (PTAC) demonstrates the complexity in creating appropriate physician-developed APMs as envisioned under MACRA. Having physician input and buy-in is critical to effective delivery system reform. More innovative health care payment and delivery models must be developed in an open and transparent fashion with the input of those specialties impacted by the models.

3. *Pass legislation requiring PTAC model submitters to consult participating and affected specialties prior to model submission.* The PTAC provides an important opportunity for specialists to develop their own models and submit them for review and recommendation to the Secretary. However, at least three models submitted to the PTAC have included pathology services, yet the CAP was not consulted or even aware they encompassed pathology services until the models were posted for public comment. Model submitters should be required to provide evidence of consultation and concurrence from specialties participating in their models prior to submission so that the PTAC can make recommendations on models that are truly physician-focused and enable meaningful contribution of their participants in enhancing the care of patients.
4. *Pass legislation requiring that traditional MIPS options be maintained for single specialty practices to ensure that private/independent practices of all sizes remain a viable option for physicians.* Traditional MIPS, though burdensome, allows single specialty pathology practices to be accurately measured on relevant quality activities and obtain full incentives without pressure to consolidate. Many pathologists in independent practice choose to stay in MIPS for that reason. The CAP believes the replacement of traditional MIPS with MVPs and Advanced APMs incentivizes larger, multispecialty practices, as the clinical alignment envisioned by these programs is often achieved via physician employment or practice consolidation. Indeed, consolidation among physician

practices and between hospitals and physician practices has accelerated in the past decade, with participation in APMs cited as reasons for consolidation.² This kind of consolidation is bad for ensuring access to quality care for patients in rural and underserved communities.

Addressing the Health Care Workforce Shortage

As you know, older adult patients require higher levels of care due to greater incidence of chronic disease, which will increase the demand for physician services on a smaller pool of available physicians. Therefore, it is imperative to grow the physician workforce. The Association of American Medical Colleges (AAMC) is projecting that the United States will face a shortage of up to 124,000 physicians by 2034. The CAP appreciates that Congress made a critical initial investment in the physician workforce by providing 1,000 Medicare-supported graduate medical education (GME) positions in the Consolidated Appropriations Act of 2021 and 200 Medicare-supported GME positions in the Consolidated Appropriations Act of 2023. However, these should be viewed as a down payment for a much larger documented need.

The demand for trained pathologists continues to far exceed the supply provided by the number of existing residency positions. Data from the CAP's 2021 Practice Leader Survey is suggestive of a nationwide demand of 1,000–1,200 pathologists to fill open positions in the United States in recent years, and these numbers are substantially lower than the demand that is being reported for 2022. In contrast, over the last decade or so, there have been approximately 620 pathologist residency positions available each year. To meet the increased demand for pathologists and other physicians, there must be a larger investment in training. As such, the CAP asks the Committee to support the following bills:

1. *Pass S. 1302, The Resident Physician Shortage Reduction Act.* S. 1302 would provide 14,000 new Medicare-supported GME positions over 7 years. While these 14,000 positions would not be enough to remedy the over 100,000 plus physician shortage, they are a critical step in the right direction. These positions would be targeted at hospitals with diverse needs, rural teaching hospitals, hospitals currently training over their Medicare caps, hospitals in states with new medical schools, and hospitals serving patients in health professional shortage areas.
2. *Encourage committee members to support S. 665; the CAP supports the Conrad State 30 and Physician Access Reauthorization Act.* S. 665 will increase the number of waivers for a state from 30 to 35 and incentivize qualified IMGs who are citizens of other nations to work in underserved communities. For agreeing to these terms, physicians will not have to leave the U.S. for 2 years before they are eligible to apply for an immigrant visa or permanent residence, thus allowing them to begin to provide necessary patient care in rural and underserved areas upon finishing their residency. IMGs are an important part of our nation's health care system and currently represent 25% of the physician workforce.

Insurer-Imposed Policies Impacting Patient Care

Increasingly, our members are experiencing instances of improper practices by insurers, which has direct implications for patient care, including those with chronic conditions, and coverage. With the passage of federal legislation to address surprise billing, health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, and other providers to shift medically necessary health care costs onto their enrollees, which can be especially burdensome to those with multiple chronic conditions. For example, although it has made changes to the program, in 2021 UnitedHealthcare tried to roll out a “benefit design” that requires laboratories to meet UnitedHealthcare-determined efficiency and quality requirements to become a “Designated Diagnostic Provider” or DDP. Facilities that did not meet these requirements (non-DDP facilities) would “remain in network,” but UnitedHealthcare would not cover outpatient diagnostic laboratory services provided by these facilities, leaving patients “liable for charges.” Even with recent modifications, the CAP believes UnitedHealthcare policies that subject patients to an increased payment for services received at in-network, but non-DDP facilities, is counter to efforts to protect patients and eliminate surprise medical bills.

² Medicare Payment Advisory Commission. 2022. March 2022 Report to the Congress: Medicare Payment Policy; Ch 4. Washington, DC: MedPAC.

Other insurers are keeping facilities in-network but imposing restrictive referral requirements that result in fractured care and added burden for patients and their physicians. For example, in situations where a biopsy leads to further hospital-based care, requiring patient samples to be sent outside the health system either prevents participation of the pathologist who is part of the multidisciplinary team or adds a second physician to the diagnosis, as the hospital-based pathologist will have to confirm the diagnosis and assume responsibility for the patient. There are also logistical challenges and risks in dividing diagnostic material for a single patient. Further, these kinds of requirements can adversely affect appropriate response to acute developments in a patient's care, and possibly cause significant delay in diagnosis. Some conditions may require rapid evaluation and treatment—not always possible when sending samples to outside laboratories—in order to prevent serious, even life-threatening complications. Additionally, for patients who live further away from the health system/hospital, returning to receive care after the results have been returned may be difficult and more likely to result in delayed care and poorer health outcomes.

Finally, other health insurance plans are slashing reimbursement across the board—or ceasing reimbursement for critical services altogether—without any individual physician/practice consideration, leaving many pathologists in serious financial jeopardy across the nation. Blanket rate cuts that lower reimbursement below the cost to provide the services threaten the financial viability of many smaller and/or rural laboratories and pathology practices. And many pathologists have little leverage or ability to opt out-of-networks with powerful insurers because of consolidation and insurer control in their health systems and communities. Further, as the American Medical Association recently wrote to the FTC and Department of Justice, “mergers of market power health insurers tend to result in lower than competitive payments to health care providers, but there is no evidence the cost savings are passed through to consumers in the form of lower premiums.” Hindering access to high-quality pathology services through reduced rates or lack of payment for pathology and laboratory services, which adversely affects patient diagnosis, treatment, and outcomes.

Insurers’ increasing adoption of abusive practices and/or reliance on inadequate networks results in adverse consequences for access to quality patient care to benefit the financial interest of the payer. Now more than ever, patients—especially those with chronic conditions—and their treating physicians are relying on the expertise of pathologists and the availability of appropriate testing.

Meaningful Sources of Health Care Spending

Finally, the CAP realizes that the policies we are advocating for cost money. However, the health of our country’s citizenry, more than anything else, impacts all facets of our nation—from national security to its economic vitality, requiring significant financial investments. Therefore, we encourage the Committee look at waste and consolidation in the health care system as a source potential source of revenue to stabilize the payment system and grow the workforce in lieu of site neutral policies. For example, the largest source of health care spending in the U.S. is administrative, with over \$265 billion a year in waste according to some studies.³ On the other hand, site neutral payment proposals fail to take into consideration the technical costs associated with specific individual codes and fail to recognize the distinct costs of physician services. Arbitrarily accepting hospital outpatient rates instead of the carefully reviewed inputs is a step backwards. The CMS has stated that comparisons between the Physician Fee Schedule (PFS) and the out-patient prospective payment system (OPPS) payments for services are inappropriate because of the different nature of the cost inputs and has explicitly refused to impose one payment system on the other.

OPPS data is hospital data and does not reflect the actual resource costs of physicians in their offices or laboratories. It reflects the average costs of “buckets” of services rather than resource costs for individual services performed by physicians. The monies are then distributed by case-mix. Complete accuracy of this data is practically impossible. OPPS rate setting allows for meaningful comparison of resource-intensiveness and costs of services within the OPPS system. But the methodology is not designed to allow for comparisons to services outside the OPPS. Current law requires physician services to be resource-based and ambulatory payment classifica-

³ “The Role of Administrative Waste in Excess U.S. Health Spending,” Health Affairs Research Brief, October 6, 2022.

tions are not resource-based. In short, site-neutral proposals could result in billions of dollars being shifted between sites of service, and potentially out of the health care system, resulting in major disruptions in health care revenue at a time when consolidation is on the rise and practices in rural and underserved areas are struggling or closing.

In closing, the CAP appreciates the opportunity to provide these comments for the record. Please contact Darren Fenwick at dfenwic@cap.org or 202-354-7135 if you have any questions regarding these comments.

Sincerely,

Donald S. Karcher, M.D., FCAP
President

EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION
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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 <https://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.

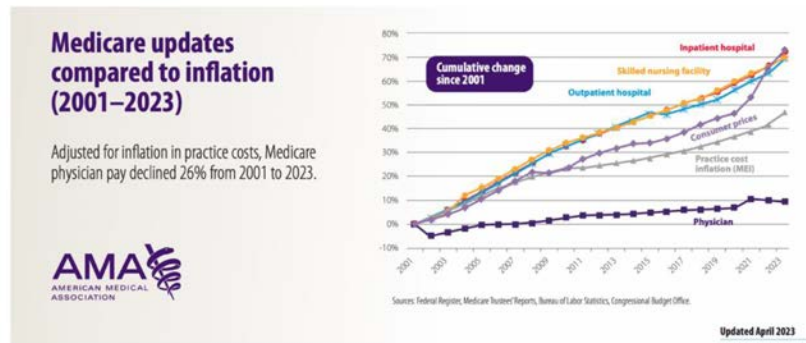
As a direct result of EMTALA, emergency physicians see a broad representation of patients, including uninsured, Medicaid, Medicare, and commercially insured patients (the average proportions are roughly 25% for each payor). It is well established that the ultimate reimbursement for uninsured, Medicaid, 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,¹ 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)*² 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.

¹ <https://www.cms.gov/oact/tr/2023>.

² [https://www.congress.gov/bills/118/congress/house-bill/2474/text?s=1&r=1&q=%7B%22search%22%3A%22HR2474%22%7D](https://www.congress.gov/bills/118/congress/house-bill/2474/text/s=1&r=1&q=%7B%22search%22%3A%22HR2474%22%7D).

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).***³

We hope this feedback is helpful to the Committee as it considers next steps for Medicare physician reimbursement.

HEALTHY AGING COALITION
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The Healthy Aging Coalition appreciates the opportunity to provide this Statement for the Record in connection with the Senate Committee on Finance hearing entitled, “Bolstering Chronic Care through Medicare Physician Payment.” The Healthy Aging Coalition consists of multiple stakeholder organizations that are committed to ensuring that all older adults live their best lives with equity, vitality, dignity, and purpose, serving as a catalyst for education, action and change. We work to build national awareness around the key challenges and issues that impact aging adults with a focus on those in rural, underserved and minority communities and to identify opportunities for stakeholders, including policymakers, to advance equitable, evidence-based, and innovative solutions.

We appreciate the Committee’s commitment to examining revisions to physician reimbursement in traditional Medicare and Medicare Advantage (MA) to enhance support for older adults managing chronic conditions. One of the Healthy Aging Coalition’s priorities is to support initiatives to reduce the prevalence of chronic conditions such as obesity, diabetes, heart disease, and Alzheimer’s Disease that promote healthy longevity by promoting wellness and prevention programs. The U.S. cannot address chronic diseases without addressing drivers of chronic conditions, such as health disparities and social determinants of health (SDOH). We are concerned that current Medicare reimbursement does not provide adequate payment for the services and support provided by physicians along with those in communities that address these drivers and, in turn, address chronic conditions. It is also important to recognize the need to stabilize Medicare Advantage and the significant progress being made via supplemental benefits. These health-related services are important to chronic care as was recently issued by CMS for the Supplemental Benefits for the Chronically Ill.

As the Committee explores changes to Medicare physician payment as a means of addressing chronic conditions, we urge that due consideration be given to ensuring reimbursement for the community services and supports that address and reduce chronic conditions. This would provide older adults a greater opportunity to achieve health and wellness.

Thank you for your leadership in taking steps to support older adults managing chronic conditions. The Healthy Aging Coalition is committed to working with the Committee to reach this goal. Please contact Vicki Shepard at vicki.shepard@tivityhealthcom should you have questions or need more information.

NAMES OF COALITION MEMBERS

American College of Lifestyle Medicine
American Society on Aging

³ <https://www.congress.gov/bills/118/congress/house-bills/6545/text/s=3&r=1&q=%7B%22search%22%3A%22H.R.6545%22%7D>.

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 Determined Health
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 Mercy Community Healthcare
 Milken Institute
 Motion Picture & Television Fund
 NashvilleHealth
 National Association of Nutrition and Aging Services Programs
 National Council on Aging
 National Minority Quality Forum
 Open Source Wellness
 PreferCare
 Sharecare
 Spark Living and Learning, LLC
 Tivity Health, SilverSneakers
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Statement of Steven K. Schmitt, M.D., FIDSA, FACP, President

On behalf of the Infectious Diseases Society of America (IDSA), which represents more than 13,000 physicians, scientists, public health practitioners and other clinicians specializing in infectious diseases prevention, care, research and education, I thank the Committee for its focus on physician payment issues, highlighting the needs of patients with chronic conditions. **IDSA asks the Committee to recognize the link between chronic diseases and infectious diseases and the critical need to reform Medicare physician payment policies to support access to infectious diseases prevention, diagnosis and treatment that can especially impact patients with chronic diseases.**

The Connection Between Chronic Disease and Infectious Disease

Chronic diseases and infectious diseases are inextricably linked. Some chronic diseases are caused by infections. Patients with chronic conditions are often at greater risk of contracting infectious diseases and suffering more serious illness from infections, as we saw with COVID-19. These issues demonstrate that infectious diseases (ID) physicians play a key role in caring for patients with chronic diseases. As the percentage of the U.S. population that is immunosuppressed (due to transplants, use of certain biologics, cancers, etc.) continues to grow, so will the need for a robust ID workforce and a payment system that enables ID recruitment and access to ID care.

Recent research has shown that many chronic illnesses result from infectious agents and can be exacerbated by infectious pathogens.¹ For example, infectious agents such as viruses, bacteria and parasites can cause cancer or increase the risks of de-

¹Knobler, S.L., O'Connor, S., Lemon, S.M., & Najafi, M. (2018). *OVERVIEW. The Infectious Etiology of Chronic Diseases*—NCBI Bookshelf. <https://www.ncbi.nlm.nih.gov/books/NBK83680/>.

veloping cancer. Certain viruses can also disturb the signals in the body that moderate cell growth and can lead to cancer developing. Cancer patients also have a much weaker immune system due to the spread of cancer to the bone marrow, thereby stopping the production of blood cells that can help in fighting infections. Furthermore, cancer treatments such as chemotherapy, steroids and radiation can weaken the immune system, making cancer patients more susceptible to infections.

The human immunodeficiency virus (HIV) is now regarded as a chronic disease that patients live with for multiple decades due to the use of antiretroviral therapy (ART).² Health care systems across the country now treat HIV patients with chronic care management models. However, ART can cause multiple complications over time. Cumulative exposure over time to antiretroviral drugs has demonstrated that HIV-infected adults are at a much higher risk for the development of cardiovascular disease, kidney disease, osteoporosis and neurocognitive disease. Patients that have been diagnosed with viruses such as HIV have weaker immune systems and are less able to fight infections that may cause cancer. HIV patients are at a higher risk for many different forms of cancer, including Kaposi sarcoma, Hodgkin's lymphoma and liver and lung cancer.³

The number of immunosuppressed adults in the United States has been increasing over time due to wider use of new immunosuppressive treatments for a broad range of conditions that are immunocompromising, including cancer, organ transplants, autoimmune disorders, rheumatoid arthritis, psoriasis and more. Immunosuppression greatly increases the risks and severity of infections. A review of 2021 data found that 6.6% of U.S. adults are immunosuppressed, a significant increase from the 2.7% reported in 2013.^{4,5} Additionally, the numbers of immunocompromised infants and children have also increased, and pediatric ID physicians provide care to a significant number of these patients who are at a much higher risk for developing serious infections.

Over the past 4 years, the medical community has seen an increase in hospitalizations and deaths due to COVID-19 in patients with chronic conditions, such as heart disease, diabetes and more.

Antimicrobial Resistance and Risk of Complications

The prevalence of antimicrobial resistance (AMR) is a growing threat to patients, including those with chronic diseases. Millions of Americans per year develop hospital-acquired infections due to antibiotic-resistant pathogens.⁶ The inappropriate use of antibiotics over decades has resulted in antibiotic resistance rates that continue to rise, with recent progress hampered by the COVID-19 pandemic.

To address the threat of AMR, IDSA greatly appreciates the leadership of Senators Michael Bennet (D-CO) and Todd Young (R-IN) in sponsoring the bipartisan PASTEUR Act, which would strengthen the antibiotic and antifungal pipeline by changing the way the federal government pays for novel antibiotics and antifungals that address unmet needs—paying for value instead of volume used. Under PASTEUR, the federal government would enter into contracts with novel antibiotic/antifungal developers to pay a set fee for a supply of new drugs regardless of the quantity used. PASTEUR would also provide grants to hospitals to support antimicrobial stewardship programs, with priority given to rural, critical access and safety net hospitals (which may partner with academic institutions for stewardship). Successful implementation of PASTEUR would require more ID physicians to ensure patients with resistant infections receive optimal treatment, lead clinical trials for novel antimicrobials and ensure that new antimicrobials are used appropriately.

²Deeks, S.G., Lewin, S.R., and Havlir, D.V. (2013). "The end of AIDS: HIV infection as a chronic disease," *The Lancet*, 382(9903), pp. 1525–1533. doi:10.1016/s0140-6736(13)61809-7.

³Risk factors: infectious agents. (2019, March 4). National Cancer Institute. <https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents>.

⁴Martinson, Melissa L., and Lapham, J. "Prevalence of immunosuppression among U.S. adults." *JAMA*, vol. 331, no. 10, 12 Mar. 2024, p. 880, <https://doi.org/10.1001/jama.2023.28019>.

⁵Harpaz, R., Dahl, R., & Dooling, K. (2016). Prevalence of immunosuppression among U.S. adults, 2013. *JAMA*, 316(23), 2547. <https://doi.org/10.1001/jama.2016.16477>.

⁶Clinical Infectious Diseases, ciad428. "AMR Guidance." IDSA Home, <https://www.idsociety.org/practice-guideline/amr-guidance/>.

Current Medicare Reimbursement Concerns

Currently, nearly 80% of counties in the United States do not have a single ID physician, and this poses significant patient access problems.⁷ Recruitment within the specialty continues to decline. In last year's fellowship match, only about 51% of ID training programs filled (down from 56% the year before), whereas most specialties filled 90%–100% of their training programs. These shortages are driven in part by reimbursement disparities that negatively impact infectious disease physicians.

Many medical students and residents are very interested in this field but cite financial reasons for pursuing specialties that have much higher reimbursement rates. Only three other medical specialties fall below ID in terms of compensation, according to Medscape. Two of those—pediatrics and public health—are primarily paid outside of the Medicare system. The shortage of ID physicians is very worrisome from a patient care and public health perspective, given the unique roles ID physicians play. ID is uniquely part of the foundation of modern health care. Cancer chemotherapy, organ transplants and other surgeries carry significant risk of infection and require ID expertise. Many hospital quality measures, conditions of participation (antimicrobial stewardship, infection prevention and control) and other metrics upon which hospital payments hinge (hospital readmissions, health care-associated infections) all fundamentally require ID physicians. ID physicians are at the forefront of leading preparedness and responses to outbreaks and pandemics. Patients with serious infections have better outcomes, shorter hospital stays and lower health care costs when cared for by an ID physician.⁸

IDSA's Proposals to Improve ID Capacity and Reimbursement

As the Finance Committee considers Medicare Physician Fee Schedule reforms, we strongly urge you to include provisions that target specialties, like ID, that are at the bottom of the payment scale and are experiencing recruitment challenges and workforce shortages directly linked to inadequate reimbursement. IDSA recommends a provision that would provide a temporary 10% incentive payment to ID physicians, modeled after similar previous efforts for primary care and general surgery. This approach would provide a critical, rapid boost that would impact the specialty decisions of current medical students and residents. It would also serve as a bridge to provide time to develop and implement longer-term solutions.

Over the last several years, IDSA has repeatedly engaged with the Centers for Medicare & Medicaid Services (CMS) to ask for assistance in addressing the reimbursement challenges that are impeding recruitment of ID physicians. Initially, we focused on urging CMS to improve the values of inpatient evaluation and management (E/M) codes, the codes mainly used by ID physicians, to maintain their historic relativity with outpatient E/M codes (whose values were increased in 2021). The historic relativity was based upon the fact that inpatient care is inherently more complex than outpatient care. Patients with serious infections often have underlying chronic illnesses, require more complex medical decision making and are at greater risk of adverse outcomes. CMS has not accepted this recommendation.

In January 2024, IDSA provided a list of services performed by ID physicians that are not adequately captured by existing E/M codes, in response to a request from CMS. At the end of February 2024, IDSA submitted to CMS draft code descriptors⁹ for infectious diseases complex prevention, infectious diseases, complex investigation/diagnosis, complex antimicrobial therapy and infectious diseases complex care management. IDSA also shared two draft code descriptors that refer more generally to complex care, to provide CMS with options that are not ID-specific: complex medication management and inpatient complex care management. The six code descriptors align with the six categories of activities routinely performed by ID physicians not adequately captured by current E/M codes. IDSA encouraged CMS to include these new codes and/or add-on codes in the upcoming CY 2025 Medicare Physician Fee Schedule rulemaking.

Several members of Congress are increasingly concerned about the ID physician workforce shortage and ID reimbursement issues. Last fall, a bipartisan group of

⁷ Walensky, Rochelle P., et al. "Where is the ID in COVID-19?" *Annals of Internal Medicine*, vol. 173, no. 7, 6 Oct. 2020, pp. 587–589, <https://doi.org/10.7326/m20-2684>.

⁸ McQuillen, Daniel P., and MacIntyre, Ann T. "The value that infectious diseases physicians bring to the healthcare system." *The Journal of Infectious Diseases*, vol. 216, no. suppl–5, 15 Sept. 2017, <https://doi.org/10.1093/infdis/jix326>.

⁹ https://www.idsociety.org/globalassets/idsa/policy-advocacy/current_topics_and_issues/antimicrobial_resistance/strengthening_us_efforts/letters-manually-added/idsa-add-on-codes-letter-and-descriptors_feb2024.pdf.

representatives sent a letter¹⁰ to CMS asking for the agency to incentivize more medical students to enter the infectious diseases field by modifying its reimbursement policy.

Like many medical specialties, IDSA is supportive of broad reforms to the Medicare physician payment system, including tying payment updates to a measure of inflation, such as the Medicare Economic Index; revising budget neutrality requirements, including raising the budget neutrality threshold; and requiring ongoing updates to the practice expense inputs that inform the value of services. These reforms are essential to addressing some of the foundational challenges that persist in the physician payment mechanism. However, these reforms alone are not sufficient to address the significant payment disparities facing ID that are driving ID recruitment challenges.

Conclusion

Thank you for your attention to physician payment issues and for considering our requests regarding the need to bolster access to ID treatment and prevention of infectious diseases through Medicare reimbursement reforms. While Medicare primarily covers adults, pediatric ID physicians face similar reimbursement and recruitment challenges that we hope to discuss in the future. We look forward to working with the Committee on these critical topics.

Should you have any questions or wish to discuss our requests further, please contact Amanda Jezek, IDSA's senior vice president for public policy & government relations, at ajezek@idsociety.org.

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April 10, 2024

The Honorable Ron Wyden
Chairman
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215 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
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Re: MGMA Statement for the Record—Senate Committee on Finance's April 11th Hearing, "Bolstering Chronic Care through Medicare Physician Payment"

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Committee for the opportunity to provide feedback on bolstering chronic care through Medicare physician payment. We appreciate your leadership in holding this important hearing as it is vital that Medicare adequately reimburse physicians for their chronic care services. Significant reforms are needed to the Medicare physician payment system to stop the harmful yearly cuts and support medical groups' ability to offer high-quality care to patients with chronic conditions.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) was enacted to repeal the flawed Sustainable Growth Rate (SGR) formula, stabilize payment rates to physicians in Medicare fee-for-service, and incentivize physicians' transition to value-based care models. While well-intentioned, MACRA's methodology for updating the Medicare Physician Fee Schedule (PFS) does not keep pace with rising practice costs and inflation, and simultaneously cuts reimbursement for physicians.

¹⁰ <https://www.idsociety.org/contentassets/2b7de28c54ae43f098838c12b2783a1f/congressman-van-drews-letter-to-cms-on-infectious-diseases-medicare-reimbursement-final.pdf>.

The Centers for Medicare & Medicaid Services (CMS) finalized a 3.37% cut to the Medicare conversion factor in its 2024 Medicare Physician Fee Schedule (PFS). From January 1st to March 8th of this year, medical groups absorbed a 3.37% reduction to reimbursement. Following congressional action to partially mitigate 1.68% of the cut in the *Consolidated Appropriations Act of 2024* (CAA, 2024), physician practices are left with a 1.69% reduction for the rest of the year.

Medicare physician reimbursement is on a dire trajectory, and these annual cuts continue to undermine the ability of medical group practices to keep their doors open and function effectively. MGMA offers the following recommendations to strengthen Medicare payment and sustainably support medical groups providing care to patients with chronic conditions.

Key Recommendations

- **Pass legislation to implement an annual inflation-based physician payment update tied to the Medicare Economic Index (MEI) to ensure medical groups have a functioning reimbursement system moving forward that keeps pace with rising costs.** Without providing an annual inflationary update for physicians—similar to other payment systems under Medicare—medical groups will continue to face financial barriers to providing access to care for patients with chronic conditions in their communities. The *Strengthening Medicare for Patients and Providers Act* would provide this long-needed annual MEI-based update to Medicare physician reimbursement.
- **Reform the budget neutrality aspect of the Medicare Part B payment system to avoid continued across-the-board payment cuts harming medical groups' financial viability.**
- **Pass the *Chronic Care Management Improvement Act of 2023* to ensure Medicare patients with chronic conditions are able to access high-quality care.**
- **Provide positive financial incentives to support practices transitioning into value-based care.** The *Value in Health Care Act of 2023* would reinstate the advanced alternative payment model (APM) incentive payment at 5%, allow CMS to set the qualifying APM participant (QP) thresholds at an appropriate level, and institute additional policies to properly incentivize and assist practices transitioning to value-based care arrangements.

Pass an Annual Medicare Inflationary Payment Update

This year's cut to the conversion factor is entirely untenable as the cost of running a medical practice continues to rise—89% of MGMA members reported an increase in operating costs in 2023.¹ According to MGMA data, physician practices saw total operating cost per FTE physician increase by over 63% from 2013–2022, while the Medicare conversion factor increased by only 1.7% over the same timeframe.

In our 2023 Annual Regulatory Burden Report, MGMA surveyed over 350 medical groups and 87% of respondents reported that reimbursement not keeping up with inflation impacts current and future Medicare patient access.² This aligns with what the Medicare Trustees recently said in their 2023 report:

While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation. In particular, additional payments totaling \$500 million per year and annual bonuses are scheduled to expire in 2025 and 2026, respectively, resulting in a payment reduction for most physicians. In addition, the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect ac-

¹ MGMA Stat Poll, July 12, 2023. <https://www.mgma.com/mgma-stat/higher-costs-persist-for-medical-groups-even-as-inflations-growth-slows>.

² MGMA 2023 Annual Burden Report, November 13, 2023. <https://www.mgma.com/federal-policy-resources/mgma-annual-regulatory-burden-report-2023>.

cess to Medicare-participating physicians to become a significant issue in the long term.³

Practices have seen significant cuts to Medicare physician payment over the past 4 years, which have a heightened impact in the face of inflationary pressures (CMS projected a 4.6% increase to the MEI for 2024) and other economic factors such as staffing shortages. Failing to stop this downward spiral in physician payment will continue to threaten the financial viability of medical groups, hasten negative repercussions to this nation's healthcare system, and hurt group practices' ability to treat patients with chronic diseases.

Other Medicare payment systems receive annual positive updates—even hospitals that received a 3.1% increase in the Medicare hospital outpatient prospective payment system (OPPS) for 2024 have decried the insufficient nature of their positive increase given financial constraints and thin margins in the current environment. How does the Committee expect physicians to keep their doors open in the same environment if Congress allows these cuts to continue?

A permanent solution is critical to stabilize Medicare physician payment. The *Strengthening Medicare for Patients and Providers Act*, which was introduced by a bipartisan group of congressional doctors in the House of Representatives and currently has 127 cosponsors, would provide an annual Medicare physician payment update tied to inflation, as measured by the MEI. This commonsense policy is long overdue to bring physician payment in line with the costs of providing care and should be enacted as soon as possible.

Modernize Medicare's Antiquated Budget Neutrality Policies

Compounding the lack of an inflation-based update are the annual reimbursement cuts medical groups continue to face stemming from 2021 Medicare PFS changes, the phase-in of the E/M complexity add-on code (G2211) that CMS implemented in 2024, and corresponding budget neutrality requirements. The *Provider Reimbursement Stability Act of 2023* would modernize many aspects of Medicare budget neutrality and would make significant changes to alleviate the adverse effects practices are experiencing. The legislation would increase the triggering threshold from \$20 million to \$53 million (while adding an update to keep pace with inflation), institute new utilization review requirements to better reflect the reality of providers using certain services compared to CMS' estimates, and more.

MGMA urges Congress to make changes to budget neutrality in unison with the long-needed annual inflationary update. These policies work in concert to undermine the financial viability of medical practices, as medical groups will be facing another cut in 2025 absent congressional intervention. Addressing both problems would go a long way towards establishing an appropriate and sustainable Medicare reimbursement system.

Support Patients With Chronic Conditions by Enacting the *Chronic Care Management Improvement Act of 2023*

Chronic care management (CCM) is an integral part of care coordination for patients with chronic conditions. Medicare started paying for CCM services in 2015 for primarily non-face-to-face CCM services. While we support this initiative to improve the ability to manage patients' chronic conditions, these services created a beneficiary cost-sharing obligation.

The 20% coinsurance requirement for CCM services is a barrier to care for beneficiaries who are not used to cost sharing for care management services. The *Chronic Care Management Improvement Act of 2023* would waive this coinsurance requirement, thereby improving patients' ability to receive the chronic care they need. We urge the Committee to pass this important piece of legislation.

Support Physician Practices Transitioning Into Value-Based Care Arrangements

Value-based care arrangements such as APMs can help physician practices successfully treat patients with complex and chronic conditions, but Congress needs to do more to ensure practices have adequate financial support to voluntarily make the transition from fee-for-service. Congress recently extended the APM incentive payment at 1.88% for 2024—a decrease from 3.5% in 2023, and 5% in 2022. MGMA strongly urges Congress to reinstate the full 5% as this payment is necessary to

³Medicare Board of Trustees, 2023 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, March 31, 2023. <https://www.cms.gov/oact/tr/2023>.

cover costs, support investments, and safeguard the financial viability of medical groups in the program.

Congress also froze the QP thresholds at the 2023 level for the 2024 performance period in the CAA, 2024. This was a welcomed extension, as CMS' increase of these thresholds would have made it extremely difficult for many medical groups to reach QP status and qualify for the APM incentive bonus and avoid onerous reporting requirements under the Merit-based Incentive Payment System (MIPS). We suggest the Committee give CMS the ability to adjust these thresholds under statute to allow them to be set at reasonable levels, as drastic increases to QP thresholds will make it impossible for many practices to join or continue participating in APMs. The *Value in Health Care Act of 2023* includes language to this effect and would implement additional policies, such as extending the 5% APM incentive payment, to better assist practices transitioning into value-based care arrangements.

Conclusion

MGMA thanks the Committee for its leadership in examining Medicare payment for chronic care. We look forward to collaborating with the Committee and its colleagues to craft sensible payment policies that will reinforce practices' ability to offer high-quality care to patients with chronic conditions. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

Anders Gilberg
Senior Vice President
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April 25, 2024

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the National Academy of Neuropsychology (NAN), we are writing to share comments and recommendations for consideration as part of your committee's April 11th hearing, "Bolstering Chronic Care through Medicare Physician Payment." NAN is an organization that represents neuropsychologists, who are doctoral experts in how brain injuries and conditions affect behavior and functional abilities. Neuropsychologists work closely with other medical specialists in the assessment and treatment of people with a variety of brain injuries and diseases, as well as promoting brain health.

You have received similar comments from our colleagues at the American Psychological Association Services (APA Services), which we have modified to identify specific considerations related to the practice of neuropsychology.

We applaud your committee's attention to improving Medicare healthcare provider reimbursement policies, as they are not adequately supporting high-quality, cost-effective health care for the program's beneficiaries. We share the concerns of the broad provider community regarding the consistent failure of payment updates for Part B providers to keep pace with inflation. Steadily eroding reimbursement rates are increasingly making Medicare participation unsustainable for psychologists and other providers. We strongly support proposals to raise the budget neutrality cap on adjustments to the Medicare Physician Fee Schedule (PFS), and to connect annual conversion factor increases to the Medicare Economic Index or similar measures of inflation. However, our comments today will focus on aspects of the Medicare fee schedule and proposed payment policies that specifically impact neuropsychological services.

Because of their foundational importance, it is important for policymakers to understand that Medicare PFS payment formula methodologies for both work and practice expenses have consistently undervalued neuropsychologists' services. This situation has been exacerbated by the statutory requirement that annual updates to the PFS be made in a budget neutral manner.

Work Valuation

As the committee has recognized, the Medicare fee schedule tends to undervalue cognitively intensive services, and neuropsychologists' services are cognitively intensive. The Centers for Medicare and Medicaid Services (CMS) has recognized the need to set more appropriate work values for psychologists' services, and in the 2024 fee schedule CMS initiated a 19.1% increase in work relative value units (RVUs) for psychotherapy services over the next 4 years. However, CMS has not adopted a similar increase for psychological and neuropsychological testing and assessment services, which are as cognitively demanding as psychotherapy services.

Psychological assessment is the process of systematically collecting reliable and valid information about behavior from multiple sources to inform decisions about a patient's mental or behavioral functioning, typically for the purpose of diagnoses, treatment planning, or treatment evaluation. Domains assessed in a psychological assessment typically consist of mood/emotional conditions and symptoms, mental status, adaptive functioning, and behavioral and interpersonal adjustment, with evaluation of acuteness vs. chronicity, severity, degree of functional impairment, comorbidity, and prognosis where information is available. Psychological testing has been shown to provide both clinical and financial benefit in treating psychiatric disorders.¹

Neuropsychological assessments provide measurements of behavioral manifestations of central nervous system (CNS) disorders using techniques that provide objectivity, validity, and reliability. Information acquired from neuropsychological assessments can directly inform medical decisions by providing data relevant to diagnosis, progression or course of conditions, prognosis, and treatment of disorders. In addition, neuropsychological assessments can aid in making accurate predictions about functional abilities across a variety of disorders.^{2,3} Neuropsychological tests are administered in the context of a comprehensive evaluation that synthesizes data from clinical interviews, record review, medical history, and behavioral observations. Where appropriate, these evaluations consider neuroimaging, other neuro-diagnostic studies, and other lab/diagnostic studies to inform neuropsychologically oriented interventions.⁴

Neuropsychological evaluation remains the most sensitive cognitive testing method for discriminating pathophysiological dementia from age-related cognitive decline, cognitive difficulties that are depression-related, and other related disorders, and are the gold standard in both reliably establishing a diagnosis and developing treatment plans by clinically justifying relevant therapies and interventions.⁵ This is important in dementia care, as medications used to treat Alzheimer's disease have virtually no benefit for patients with other forms of dementia. An estimated 17% of Medicare beneficiaries with vascular dementia and 8% with Parkinson's disease are initially misdiagnosed with Alzheimer's disease, resulting in unnecessary treatment costs until they are accurately diagnosed.⁶

CMS stated in the CY 2024 proposed rule, "because the physician/practitioner work RVU is developed based on the time and intensity of the service, the issues regarding the valuation of these types of services are particularly pronounced for services

¹Durosini, I., & Aschieri, F. (2021). Therapeutic assessment efficacy: A meta-analysis. *Psychological Assessment*, 33(10), 962–972. <https://doi.org/10.1037/pas0001038>.

²Chaytor, N. & Schmitter-Edgecombe, M. (2003). The ecological validity of neuropsychological tests: A review of the literature on everyday cognitive skills. *Neuropsychology Review*, 13, 181–197.

³Gure, T. R., Kabeto, M. U., Plassman, B. L., Piette, J. D., & Langa, K. M. (2010). Differences in functional impairment across subtypes of dementia. *Journals of Gerontology: Biological Sciences and Medical Sciences*, 65, 434–441.

⁴Board of Directors. (2007). American Academy of Clinical Neuropsychology (AACN) practice guidelines for neuropsychological assessment and consultation. *The Clinical Neuropsychologist*, 21, 209–231.

⁵Weintraub S. Neuropsychological Assessment in Dementia Diagnosis. *Continuum* (Minneapolis, Minn.). 2022 Jun 1;28(3):781–799. doi: 10.1212/CON.0000000000001135. PMID: 35678402; PMCID: PMC9492323.

⁶Hunter CA, Kirson NY, Desai U, Cummings AK, Faries DE, Birnbaum HG. Medical costs of Alzheimer's disease misdiagnosis among U.S. Medicare beneficiaries. *Alzheimer's Dement*. 2015 Aug;11(8):887–95. doi: 10.1016/j.jalz.2015.06.1889. Epub 2015 Jul 21. PMID: 26206626.

that are billed in time units (like psychotherapy codes) that directly reflect the practitioner time inputs used in developing work RVUs, compared to other services that are not billed in time units in which work RVUs are based on estimates of typical time, usually based on survey data.”⁷

As with psychotherapy services and their corresponding codes, all psychological and neuropsychological testing services are time-based services and meet CMS’ rationale for the proposed increase in value. We believe that parallel increases in the work RVUs for all psychological and neuropsychological testing and assessment services are warranted to maintain relativity across the current procedural terminology (CPT) codes, and to avoid disincentivizing provision of these services.

Supporting Neuropsychology Integration in Alternative Payment Models

In order to effectively respond to the needs of older adults with chronic conditions, it is imperative that new payment models and incentives adequately support integrated primary and behavioral/cognitive healthcare. For example, Integrated primary care, in which primary care and neuropsychologists work together as a team to assess and care for patients and their families, can improve patient outcomes and satisfaction with care and reduce overall treatment costs. It can also increase access to mental health treatment, since as many as 80% of patients with a mental illness visited a primary care provider within the last year, and up to 75% of primary care visits include mental or behavioral health components, including behavioral factors related to chronic disease management and patient health and well-being.^{8,9} In addition to improving the identification and treatment of individuals with behavioral disorders and care of patients’ chronic conditions, research shows that integrated care can reduce treatment costs. One study found that integrating a psychologist into a primary care practice resulted in cost savings of \$860 per member per year.¹⁰ We applaud the Committee’s approval of the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act, and its provisions in Sec. 104 to support adoption of evidence-based models of integrated care. We urge the Committee to continue to support integrated care in its development of new payment models and policies.

Payment models, such as CPC+ were intended to incorporate care coordination and behavioral health integration as cost effective means of improving health outcomes. However, these models remain based in Medicare’s fee for service structure and lack accountability for behavioral health outcomes and integration. The CMMI Primary Care First model builds on CPC+ and moves practices closer to taking on full risk, while focusing on high need, seriously ill patients. Yet, like CPC+ and Patient Centered Medical Homes, it focuses on physical health rather than behavioral health outcomes. Without adequate quality metrics, there is limited accountability and assessment of the value of integration.” (p. 51)

We were pleased to hear discussion of the CMS Innovation Center’s Guiding an Improved Dementia Experience (GUIDE) Model8 during the hearing. The GUIDE model represents an innovative structure of care management that recognizes the critical role caregivers play in management of dementia and allows for provision of services that benefit an individual patient directly and indirectly via caregiver education, support, and respite services. As noted in the CMS description, “dementia affects more than 6.7 million Americans in 2023,” and fragmentation in care leads to inaccurate or delayed diagnosis and increased contact with emergency services and hospital admissions, resulting in rising costs and poorer outcomes. Provider-based, fee-for-service models do not take into account the value of preventing unnecessary emergency and admission services. The GUIDE model builds upon existing care management programs, some of which were created by neuropsychologists.⁹ In the GUIDE model, the first recommendation in identifying beneficiaries is to utilize an interdisciplinary approach to the “Initial Comprehensive Assessment Visit,” which includes a cognitive assessment. Such programs add value via direct payments, improved diagnostic and risk specificity, and savings due to reduction in costly intervention through case management and caregiver support services.¹⁰

⁷ Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. 88 Fed. Reg. 52262. (proposed August 7, 2023).

⁸ <https://www.cms.gov/priorities/innovation/innovation-models/guide>.

⁹ Guterman EL, Kiekhoefer RE, Wood AJ, et al. Care Ecosystem Collaborative Model and Health Care Costs in Medicare Beneficiaries With Dementia: A Secondary Analysis of a Randomized Clinical Trial. (2023). JAMA Intern Med. 183(11):1222–1228. doi:10.1001/jamainternmed.2023.4764

¹⁰ Robert John Sawyer et al. (2023). Making the Business Case for Value-Based Dementia Care, NEJM Catalyst. DOI: 10.1056/CAT.22.0304.

We appreciate the opportunity to provide these comments on this critical issue, and we look forward to working with the committee to establish more effective Medicare payment policies for the benefit of the program's millions of beneficiaries.

Sincerely,

William Perry, Ph.D.
Executive Director and Past-President

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The National Association of ACOs (NAACOS) appreciates the opportunity to submit a statement to the Senate Committee on Finance in response to the hearing "Bolstering Chronic Care through Medicare Physician Payment." NAACOS represents more than 430 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS members serve over 9 million beneficiaries in Medicare value-based payment models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs). NAACOS appreciates the committee's leadership and commitment towards improving the Medicare payment system. Our statement reflects the shared goal of our members to advance value-based care.

APMS ARE A PLATFORM FOR IMPROVING CHRONIC CARE MANAGEMENT

A key aim of health care should be keeping patients healthy and supporting them with getting the right services, at the right time, in the right place. Unfortunately, Medicare's fee-for-service (FFS) payment system can lead to care fragmentation that results in reactive, sickness-based care. This means higher costs and less coordinated care for patients. The current physician payment system also underinvests in primary care and care coordination and does not account for adequately paying providers as costs rise. As a result, physician practices have limited funding or tools to proactively manage complex patient care. Stabilizing Medicare's payment system and ensuring payment adequacy along with strong incentives to adopt infrastructure and staffing necessary for population health is needed to transition into payment models that focus on outcomes.

APMs have proved to be the solution. Over the last 2 decades, the growth of APMs has enabled health care providers to work as a team and make necessary investments that result in better outcomes and reduced costs. APMs are becoming more rooted in our health care system but growth has been slower than Congress' original goal. It is essential to remove barriers to participation and give additional flexibility and tools to innovate care.

ACOs Are the Largest APM Leading Medicare's Value Transformation

The MSSP is the largest and most successful value-based care program in Medicare, and as such it should be utilized as an innovation platform. In 2024, there are 602 ACOs coordinating care for 13.4 million Medicare beneficiaries. ACOs are a voluntary alternative to the fragmented FFS system that gives doctors, hospitals, and other health care providers the flexibility to innovate care and holds them accountable for the clinical outcomes and cost of treating an entire population of patients.

With primary care as the backbone, ACOs employ a team-based approach that allows clinicians to ensure patients receive high quality care in the right setting at the right time. ACOs improve quality while controlling costs through primary care-focused initiatives such as expanded primary care teams, care coordination strategies, and enhanced data and analytics tools for primary care practices.¹ The ACO model also provides an opportunity for providers to work collaboratively along the continuum while remaining independent.

¹ https://journals.lww.com/hcmrjournal/Fulltext/2019/04000/Clinical_coordination_in_accountable_care.5.aspx.

Importantly, ACOs provide shared savings opportunities and enhanced regulatory flexibility that allows clinicians to maintain financial security while practicing medicine more freely. For example, many primary care practices were financially harmed by the effects of the COVID-19 pandemic, and evidence showed that independent primary care practices participating in ACOs were better-equipped to respond to the crisis, supported by alternative revenue sources and workflow tools made available through ACO participation.

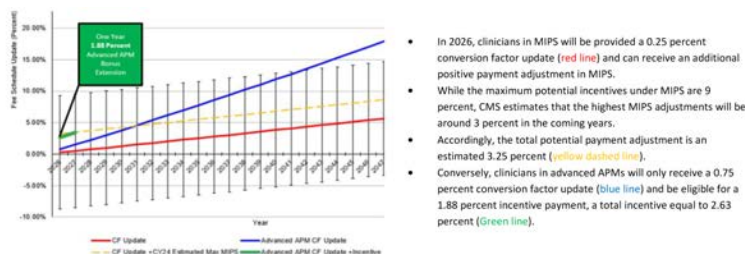
It's clear these payment system reforms have been a good financial investment for the government. In the last decade, ACOs have generated more than \$22.4 billion in savings with \$8.8 billion being returned to the Medicare Trust Fund while maintaining high quality scores for their patients. The growth of APMs has also produced a "spill-over" effect on care delivery across the nation, slowing the overall rate of growth of health care spending. Providers in APMs also help make the Medicare program stronger by reducing improper payments. Using enhanced data and analytics, ACOs regularly identify and report instances of fraud, waste, and abuse.

Develop Solutions to Improve Physician Payment and Encourage the Movement to Value

The Medicare Access and CHIP Reauthorization Act (MACRA) included advanced APM incentive payments to encourage providers to move into risk-based payment models while also providing funds that allow them to cover services not reimbursed by traditional Medicare (*e.g.*, meals programs and transportation). These are the types of services that help address patients' social needs, keep patients healthier, and lower costs. MACRA also included a higher conversion factor update for clinicians in advanced APMs, however this does not adequately address inflation, creates more complexity for clinicians, and could make it harder for clinicians in APMs to successfully meet program financial targets.

While NAACOS is pleased that Congress passed another short-term extension of MACRA's advanced APM incentives, it does not go far enough to drive long-term movement to value-based care. The next year when financial incentives favor clinicians that participate in risk based APMs, over those who remain in FFS, will be 2032 (see graph below).

For clinicians in advanced APMs, the 1.88 percent incentive for 2024 and higher conversion factor is a lower incentive than the maximum Merit-based Incentive Payment System (MIPS) adjustment, which is estimated to be just over 3 percent. As the incentive structure shifts, some clinicians may choose to voluntarily shift back to MIPS because the program will continue to offer opportunities for high performing clinicians in APMs to qualify for higher financial incentives.



The 1.88 percent advanced APM incentive will also expire at the end of 2024. The expiration of APM incentives will mean a significant incentive shift towards MIPS in the short term. APM adoption has been steadily growing but still falls below Congress' original goals of transitioning all clinicians into models with financial risk.

Going forward the committee should:

1. Develop approaches that account for inflation in payment updates.
2. Maintain stronger financial incentives for physicians that move into APMs.
3. Ensure that incentives do not impact a clinician's ability to meet financial targets in APMs.

Reduce Program Complexity & Improve Scaling of Innovation

MACRA created nonfinancial incentives for clinicians in APMs by exempting them from regulatory burdens associated with the FFS payment system. Unfortunately,

program complexity can lead to less participation in value models. Additionally, clinicians can be hesitant to participate in Innovation Center model tests because the models do not have a predictable pathway to permanence.

Going forward the committee should:

- Reduce program complexity by ensuring that clinicians in APMs are not required to engage in duplicative quality reporting efforts.
- Emphasize that MIPS should prepare clinicians for and encourage adoption of APMs.
- Ensure that promising aspects of innovative models have a more predictable pathway for becoming permanent.

While updating Medicare's payment system and incentive structure will take time, in the short term, the committee should advance the Value in Health Care Act (H.R. 5013/S. 3503). This bipartisan bill was introduced by Senators Sheldon Whitehouse (D-RI), John Barrasso, M.D. (R-WY), Peter Welch (D-VT), Thom Tillis (R-NC), Bill Cassidy, M.D. (R-LA), John Thune (R-SD), and Marsha Blackburn (R-TN). It makes several important reforms to ensure that APMs continue to provide high-quality care for Medicare beneficiaries, including:

1. Providing a multi-year commitment to reforming care delivery by extending MACRA's original 5 percent advanced APM incentive for 2 years to continue to encourage the movement to value.
2. Ensuring that qualifying thresholds remain attainable to promote program growth by freezing them at 50 percent for 2 years and giving the Centers for Medicare & Medicaid Services (CMS) authority to adjust thresholds through rulemaking and set varying thresholds for more targeted models where participants (*e.g.*, specialists) cannot meet the existing one-size-fits-all thresholds.
3. Removing the revenue-based designation in MSSP that penalizes certain ACOs, especially those including rural and safety net providers.
4. Establishing guardrails for CMS to ensure that the process to set financial benchmarks is transparent and appropriately accounts for regional variations in spending, to prevent arbitrary winners and losers.
5. Directing CMS to establish a voluntary, full-risk track within programs like the MSSP and has the U.S. Department of Health and Human Services provide more technical assistance to new APM participants.
6. Directing the Government Accountability Office to evaluate the potential of parity between APMs and Medicare Advantage (MA), so policymakers can seek greater alignment between the programs to ensure that both models provide attractive, sustainable options for innovating care delivery, and to ensure that APMs do not face a competitive disadvantage.

Build on the Innovation Center's Successes

As the Center for Medicare and Medicaid Innovation (CMMI) tests new payment models, successful models, or key aspects of those models, should be embedded as permanent parts of Medicare via the MSSP. While the MSSP currently includes various participation options with increasing levels of risk and reward, there is currently no full-risk option for ACOs participating in MSSP. Congress should direct CMS to create a separate full-risk option within MSSP to serve as a better bridge between it and ACO REACH. This "Enhanced Plus" Track should include greater flexibility in payment design and available waivers. As the only permanent total cost of care model in Medicare, the MSSP should be adapted to remain a viable option for more advanced ACOs and further advance value-based care.

Population-Based Payments for Primary Care

More flexible payment mechanisms can support care delivery transformation, strengthen primary care, and increase participation in ACO initiatives. CMS recently launched the ACO Primary Care Flex model, which will allow MSSP ACOs to offer prospective population-based payments for primary care. NAACOS has been advocating for this approach, which will bolster primary care practices in ACOs. Shifting to prospective payments provides primary care practices with stable and predictable cash flow needed to transform care delivery and provide comprehensive, team-based care. For more than a decade, the ACO model has improved beneficiary outcomes, generated savings to Medicare and allowed practices to invest shared savings into innovation and patient care. This model builds on the success of MSSP while recognizing we must continue to evolve the program for growth to continue.

While we are extremely pleased with the model, we are concerned that excluding high-revenue ACOs will prevent many independent primary care practices who have partnered with their local health systems from taking advantage of these much-

needed innovations. The premise of ACOs is to bring together providers from across the continuum of care to provide improved care for beneficiaries. This is a primary example of why the committee should support removing the revenue-based designation in MSSP that continues to penalize certain ACOs.

Expand Waivers for APMs

Current law allows CMS to waive certain Medicare FFS requirements in MSSP and other APMs. This is a critical component of APMs as it allows providers to operate with fewer restrictions leading to a reduction in provider burden and increased care innovation. However, the waivers to date have been limited and can also be burdensome for providers. For example, MSSP only has waivers for telehealth and the 3-day rule for skilled nursing facility stays. Yet the ACO REACH model has access to many more waivers. We believe all APMs should have access to all available waivers and that those waivers shouldn't be limited to certain models. Congress should direct CMS to establish a common set of waivers for APMs.

Chronic care management (CCM) is also a critical part of coordinated care. Unfortunately, Medicare's current CMM codes include a beneficiary cost-sharing obligation that creates barriers to care. While APMs offer opportunity to allow providers to reduce beneficiary cost sharing to ensure patients receive enhanced care management, we encourage the committee to look at legislative options to waive the beneficiary coinsurance related to CCM. This would help ensure that more chronically ill Medicare patients can receive access to high-quality care.

Improve Approaches to Test and Scale Innovation

While CMMI has been successful in testing innovative payment arrangements and increasing adoption of APMs, the success of these models is not captured within current evaluation approaches. Congress should work with CMS to ensure that promising models have a more predictable pathway for being implemented and becoming permanent and are not cut short due to overly stringent criteria. This includes broadening the criteria by which CMMI models qualify for Phase 2 expansion and directing CMMI to engage stakeholder perspectives during APM development.

Establish Parity Between APMs and Medicare Advantage Program Requirements

Recognizing ACOs' and MA's shared goals of improving the quality of care and cost savings to patients, it's imperative to build parity between the two programs. Misaligned incentives are harmful to advancing value as they increase provider burden, create confusion and disincentives for patients, and generate market distortions that favor one entity over another. Parity can be better provided in the programs' benchmark and risk adjustment policies, quality measurement, and marketing requirements. ACOs should be allowed to provide comparable benefits to those offered to MA patients, such as telehealth visits, transportation benefits, home visits, etc. Without parity, providers are forced to spend time managing the various program requirements rather than managing patient care. Congress should direct GAO to evaluate how to create more parity between APMs and MA. Additionally, Congress should explore opportunities to incentivize MA plans to enter risk-bearing arrangements with providers.

We thank the committee for this opportunity to provide feedback on this important hearing. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on bolstering CCM through payment system reforms. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha-pittman@naacos.com

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April 24, 2024

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Dear Chair Wyden and Ranking Member Crapo,

The Obesity Care Advocacy Network (OCAN) appreciates the opportunity to provide the following comments to the U.S. Senate Finance Committee in response to its April 11th hearing on “Bolstering Chronic Care through Medicare Physician Payment.” We are hopeful that the Committee will include payment reforms in any legislation being considering to address chronic disease care for Medicare beneficiaries, which promote greater access to comprehensive obesity care.

Founded in 2015, OCAN is a diverse group of organizations focused on changing how we perceive and approach obesity in the United States. OCAN works to increase access to evidence-based obesity treatments by uniting key stakeholders and the broader obesity community around significant education, policy and legislative efforts. We aim to fundamentally change how the U.S. healthcare system treats obesity, and to shift the cultural mindset on obesity so that policymakers and the public address obesity as a serious chronic disease.

Obesity is a progressive disease, and without treatment Medicare beneficiaries with overweight or obesity risk further health deterioration and an increased likelihood in the onset of related comorbid conditions including obesity-related cancers, diabetes, and end stage renal disease. Additionally, people with severe obesity have a 48% higher risk of physical injury including falls which lead to higher costs and mortality rates. Congress must take steps to address this crisis now.

Medicare’s Physician Payment System Must Recognize and Support Co-ordinated Care for Patients Living with Obesity

Medicare must issue guidance that obesity should be a recognized disease state for purposes of Medicare chronic care management codes. Medicare payments for non-face-to-face chronic care management services are traditionally not allowed for these services when they are utilized to treat and manage obesity because obesity is not listed in the Medicare Chronic Conditions Chartbook. The obesity community raised this issue more than a decade ago when CMS proposed establishing the chronic care management codes.

The Chartbook highlights the prevalence of chronic conditions among Medicare beneficiaries and the impact of chronic conditions on Medicare service utilization and spending. Since 2013, the obesity community has argued that the Chartbook should include obesity especially given that 13 of the 15 conditions listed (high blood pressure, high cholesterol, ischemic heart disease, arthritis, diabetes, heart failure, chronic kidney disease, depression, COPD, atrial fibrillation, certain cancers, asthma, and stroke) are commonly associated with obesity and/or are exacerbated by obesity.

Obesity clearly meets the criteria CMS outlined in the proposed rule as the rational for selecting the 15 conditions eligible for the chronic care management payments. Specifically, (1) obesity is highly prevalent among the Medicare population; (2) obesity is chronic, *i.e.*, typically lasts for more than 12 months; (3) obesity poses increased risk for death, acute exacerbation/decompensation, or functional decline; (4) obesity results in increased use of health care services; and (5) successful care management of obesity can improve outcomes/reduce costs.

The prevalence of obesity in older adults is high.

The obesity epidemic has had a negative impact on our nation’s health and economy. Among older adults (aged 60+), the prevalence of obesity is 42.8%, similar to the level among younger and middle-aged adults. The prevalence of severe obesity among those aged 60+ is 5.8%. More than 20% of the population will be 65 years of age or older by 2030, up from 15% today, highlighting the importance of addressing obesity among older Americans.

Obesity is a chronic disease, which typically lasts well longer than 12 months.

Obesity is a chronic disease that poses lifelong challenges for many individuals. In addition to the obesity community and the American Medical Association, numerous other healthcare professional organizations, such as the American Heart Association, American Diabetes Association, and the American Association of Clinical Endocrinologists define obesity as a chronic disease. Obesity is also recognized as a chronic disease in the NHLBI Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, which state, “Obesity is a complex multifactorial chronic disease developing from interactive influences of numerous factors—social, behavioral, physiological, metabolic, cellular, and molecular.”

It is also important to note the broad recognition of obesity as an independent, complex disease state by numerous federal agencies, including the Social Security Administration (SSA), National Institutes of Health (NIH), Food and Drug Administration (FDA), Veterans Affairs (VA), Centers for Disease Control and Prevention (CDC), and the Internal Revenue Service (IRS).

Obesity poses increased risk for death, acute exacerbation/decompensation, or functional decline.

Studies¹ have demonstrated that obesity results in higher morbidity for a range of health conditions—including many on the list of 15 chronic conditions proposed by CMS—hypertension, type 2 diabetes, coronary heart disease (CHD), stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some types of cancer (endometrial, breast, prostate, and colon), among others. Approximately 75%² of people with severe obesity have at least one co-morbid condition, often type 2 diabetes, hypertension or sleep apnea, which increases the risk of premature death.

Obesity results in increased use of health care services.

Adults with obesity in the United States compared with those with normal weight experienced higher annual medical care costs by \$2,505 or 100%, with costs increasing significantly with class of obesity, from 68.4% for class 1 to 233.6% for class 3. The effects of obesity raised costs in every category of care: inpatient, outpatient, and prescription drugs. Increases in medical expenditures due to obesity were higher for adults covered by public health insurance programs (\$2,868) than for those having private health insurance (\$2,058). In 2016, the aggregate medical cost due to obesity among adults in the United States was \$260.6 billion.³

Successful care management of obesity can improve outcomes/reduce costs.

The benefits of care management in individuals with obesity have been well documented. For example, a recent University of Southern California Schaeffer Center study on the “Benefits of Medicare Coverage for Weight Loss Drugs”⁴ estimated the benefits of treating Americans living with obesity and the cost-offsets that Medicare and society could accrue if laws were changed to allow Medicare to cover AOMs. The study found that coverage for new obesity treatments could generate approximately \$175 billion in cost offsets to Medicare in the first 10 years alone. By 30 years, cost offsets to Medicare could increase to \$700 billion. The positive impacts extend beyond Medicare—with society possibly reaping as much as \$100 billion per year (or \$1 trillion over 10 years) of social benefit in the form of reduced healthcare spending and improvements in quality of life from reduced disability and pain if all eligible Americans were treated.

OCAN also remains concerned that coverage for services to prevent, manage, and/or treat chronic conditions such as diabetes, prediabetes, and obesity currently exists as a patchwork within CMS with persistent gaps and limitations related to the receipt of same-day service, referrals, coverage levels, payment, and sites of service.

One prime example of these problems surrounds the 2011 National Coverage Determination for Intensive Behavioral Therapy for Obesity (210.12) (the “2011 NCD”) to modify the limitations that this service only be delivered by primary care providers (physicians, nurse practitioners (NPs), physician associates (PAs)) in a primary care setting. CMS should reconsider the 2011 NCD to allow other qualified healthcare providers (*i.e.*, registered dietitians, clinical psychologists, specialty physicians and specialty NPs and PAs) to independently provide and bill for this service upon referral from the primary care provider without limitation to the primary care setting.

We appreciate the commitment made by the Biden Administration in its National Strategy on Hunger, Nutrition and Health to “expand Medicare beneficiaries’ access to . . . obesity counseling. We also appreciate the interest expressed in the CY 2023 Medicare Physician Fee Schedule to “understand what existing services within current Medicare benefits may represent high value, potentially underutilized services” and the request for information about “obstacles to accessing these services and how specific potential policy, payment or procedural changes could reduce potential obstacles and facilitate better access to high value health services.” The original IBT for Obesity benefit resulted in unintended administrative burdens and unnecessary

¹ <https://www.ncbi.nlm.nih.gov/books/NBK2003/>.

² <https://jamanetwork.com/journals/jama/fullarticle/192030>.

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10394178/>.

⁴ <https://healthpolicy.usc.edu/research/benefits-of-medicare-coverage-for-weight-loss-drugs/>.

expenses that could be remedied through a reconsideration of the benefit's 2011 NCD.

Again, OCAN appreciates the opportunity to offer these recommendations to the Committee regarding potential reforms to the Medicare Physician Payment System to better address chronic disease care for Medicare beneficiaries. Should you have any questions or need additional information, please feel free to contact us.

Sincerely,

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The Primary Care Collaborative and our Better Health—NOW Campaign partners thank the Senate Finance Committee for convening the hearing and for this opportunity to submit a statement for the record. As it examines the sweep of issues related to Medicare payment, we urge the Finance Committee to put Medicare primary care at the center of its work.

High-quality, whole-person primary care is an essential foundation for any proactive strategy to address chronic physical and mental health conditions and the increasingly unaffordable costs they generate. The National Academies of Sciences, Engineering and Medicine's (NASEM) 2021 consensus report, *Implementing High-Quality Primary Care*, found that "primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes."¹

Primary care payment reform can unlock powerful improvements in quality and real cost savings, particularly in public programs that shape the entire marketplace. Within the Medicare Shared Savings Program, primary care centric ACOs reduced preventable downstream costs compared to other ACOs and produced twice the shared savings as other, hospital-based ACOs.² For certain practices, states and geographies, the CMS Innovation Center has also introduced new or re-tooled promising primary care models, including Making Care Primary, ACO Primary Care Flex and ACO REACH.

Despite these bright spots, our overall health care system's priorities remain out of balance, devoting less than five (4.7) cents of each dollar to primary care in 2021.³ Most primary care practices report no participation in either shared savings or population-based payment.⁴ In 2023, an estimated 1 in 4 (28.7%) Americans lack a

¹The National Academies of Sciences, Engineering and Medicine. (2021, May). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. [Nationalacademies.org](https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care). <https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care>.

²*Improve Care in Medicare by Growing Primary Care in ACOS*. Primary Care Collaborative. (2024b, March). <https://thepcc.org/resource/improve-care-medicare-growing-primary-care-acos>.

³*The health of US Primary Care: 2024 Scorecard Report—No One Can See You Now*. Milbank Memorial Fund. (2024b, February 29). <https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/>.

⁴Horstman, C., & Lewis, C. (2023, April 13). *Engaging Primary Care in Value-Based Payment: New Findings from the 2022 Commonwealth Fund Survey of Primary Care Physicians*.

Continued

usual source of care⁵ and rural and underserved communities, in particular, face widening gaps in access.⁶

Reorient Medicare Payment toward Primary Care and Prevention

Over time, policy choices guiding Medicare Part B's fee-based payment structure have generated distortions that have systematically undercut investment in primary care⁷ and contributed to growing health disparities, based on geography, race and ethnicity.⁸ This persistent under-resourcing of primary care is an obstacle to the health of Medicare beneficiaries and the sustainability of the primary care workforce. Moreover, because all Medicare APMs and most private APMs are built upon the Medicare Physician Fee Schedule to one extent or another, shortcomings in Medicare's support for primary care are magnified throughout the nation's entire health care system.

To address the rising tide of chronic disease discussed in the April 11th hearing, policymakers must fix the underlying flaws in Medicare Part B's payment policies. Below, we detail our initial recommendations to the Committee in this regard.

Enhance Transparency: As noted above, America's allocation of health care dollars is deeply unbalanced, devoting just 4.7 cents for each dollar spent to primary care.

Congress should require HHS to follow the lead of more than twenty states⁹ and report primary care spending as a share of total spending. This requirement should apply to traditional Medicare, Medicare Part C and across federal programs.

Give Primary Care Practice a Choice: An Alternative to Fee-for-Service: Better Health—NOW supports efforts to rapidly transition primary care payment from a predominantly fee-for-service model to predominantly population-based prospective payment (hybrid) models. These new models must include up-front and ongoing investments, as well as guardrails to assure quality and access in rural and underserved communities.

To that end, the Finance Committee should work with stakeholders toward legislative solutions that make a well-constructed primary care hybrid payment option broadly available. Under such an approach, payment would be provided to practices upfront each month to deliver primary care for patients with an ongoing relationship, coupled with FFS payment for other services. The design and implementation of hybrid payment should:

- invest in primary care capacity, support personalized, team-based care and pay for services tailored to the needs of the patient and the community;
- reduce or simplify the burdensome documentation associated with many FFS codes, which add to systemic costs and consume clinician time that could be better spent with patients; and
- allow for additional, higher payment tiers based on the scope of services included in such payments, such as greater behavioral health integration and ability to address health-related social needs.

Enhance Primary Care Affordability in Medicare: As part of any Medicare payment reform legislation, Congress should remove financial barriers patients face in accessing the comprehensive, whole-person primary care necessary to manage their chronic conditions. **We support**

- **authorizing patient cost-sharing waivers for the services provided prospectively as part of any hybrid primary care payment,**

<https://www.commonwealthfund.org/blog/2023/engaging-primary-care-value-based-payment-new-findings-2022-commonwealth-fund-survey>.

⁵The Health of US Primary Care: 2024 Scorecard Report—No One Can See You Now. Milbank Memorial Fund. (2024b, February 29). <https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/>.

⁶Rural-Urban Disparities in Health Care in Medicare—CMS. Centers for Medicare and Medicaid Services. (2023, November). <https://www.cms.gov/files/document/rural-urban-disparities-health-care-medicare-national-report.pdf>.

⁷MedPAC (Medicare Payment Advisory Commission). 2006. Report to the Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission.

⁸McNeely, L., Douglas Megan, Westfall, N., Greiner, A., Gaglioti, A., & Mack, D. (2022). PRIMARY CARE: A Key Lever to Advance Health Equity. The Primary Care Collaborative. <https://theccc.org/sites/default/files/resources/PCCNCPC%20Health%20Equity%20Report.pdf>.

⁹See PCC's State Primary Care Investment HUB for information on state based legislation measuring and reporting primary care spend, available at <https://theccc.org/primary-care-investment/legislation>.

- **eliminating cost-sharing for Medicare's behavioral health integration services (Section 102 of S. 923 the Better Mental Health Care for Americans Act) and**
- **removing cost-sharing requirements for Chronic Care Management codes (HR 2829, the Chronic Care Management Improvement Act).**

Accelerate Primary Care-Behavioral Health Integration: Research has shown that evidence-based, primary care integration models, like the Collaborative Care Model and Primary Care Behavioral Health, can successfully improve outcomes while making better use of an overstretched mental health workforce. In 2016, Medicare established payment codes to support the delivery of the collaborative care model and general behavioral health integration services. The Centers for Medicare and Medicaid Services and Congress have taken steps in the years since to further support integrated care. Unfortunately, availability of evidence-based, integrated primary care has been badly outpaced by patients' growing need for mental health and addiction services.

To address the present crisis in behavioral health and strengthen the health of Medicare beneficiaries and their communities, **Better Health—NOW supports S. 1378, the COMPLETE Care Act and S. 3157 the More Behavioral Health Providers Act.** We appreciate the inclusion of these measures in the Better Mental Health Care, Lower Cost Drugs and Extenders Act of 2023, and urge all members of the Committee to press for enactment of these provisions this year. The More Behavioral Health Providers Act extends and expands the Health Professional Shortage Area program to help communities attract behavioral health clinicians needed to support integrated primary care teams. The COMPLETE Care Act provides for technical assistance and enhanced reimbursement for integrated care services.

In light of the dual crises of mental health and addiction, we encourage the Committee to consider additional steps. One approach would be to remove expenditures on Collaborative Care Management (CoCM) and General Behavioral Health Integration codes from the expenditures compared against spending benchmarks in MSSP and other benchmark-based payment models. Accountable payment has the potential to support broader adoption of behavioral health-primary care integration. But because expenditures associated with delivering the services can increase spending over the short term, benchmark-based payment models like MSSP have a built-in disincentive to the delivery of and billing for integrated behavioral health. We encourage you to explore how to address this issue.

(For more information, please see PCC/BHN responses to the Senate Finance Committee's bipartisan mental health legislative work here and here.)

Support Private Sector and State Payment Innovation

Primary care practices rarely serve only traditional Medicare enrollees and rely on other payers to remain viable and sustain services for all their patients, including Medicare beneficiaries. To succeed, Medicare primary care payment innovations should align with payment innovations by state Medicaid programs, as well as those advanced by private market payers and purchasers. In tandem with its Medicare payment reform work, the Finance Committee should pursue targeted policy steps this year that support constructive state Medicaid and private market primary care innovations, including the following.

Strengthen Primary Care in Rural and Underserved Communities, Leveraging Medicaid and CHIP

Strengthening primary care for Medicaid and CHIP beneficiaries is an essential complement to reforming Medicare payment. Medicaid and CHIP cover more than 80 million Americans, including a disproportionate percentage of rural people, low-income seniors, people with disabilities, and people of color. Yet, Medicaid primary care payment averages just 78% of Medicare's. Congressional leadership is necessary to ensure practices and clinics serving these communities can sustain primary care access. The following represent essential and immediate steps:

- **Enact S. 2556 the Improving CARE for Youth Act**, which eliminates payment restrictions on primary care and behavioral health services delivered on the same day for children in Medicaid/CHIP.
- **Work with the Health, Education, Labor and Pensions Committee to provide longer-term funding for the Community Health Center Fund and increase the yearly outlay for the Fund to help Federally Qualified Health Centers reach more rural and underserved communities.**

(For more information on strengthening primary care in Medicaid, see PCC's report Access and Equity in Medicaid.)

Encourage Primary Care Access Innovations in the Private Market: According to the Centers for Disease Control and Prevention (CDC), in 2017 nearly a quarter of individuals with employer sponsored insurance were enrolled in high deductible plans without a health savings account.¹⁰ Over 50 percent of individuals with an HSA live in zip codes where the median income is below \$75,000 annually.¹¹ Yet HSA/HDHPs are barred from covering many primary care services until a patient meets their full deductible.

To address this barrier to primary care, Congress should broaden the preventive services safe harbor for High-Deductible Health Plans to facilitate pre-deductible access to comprehensive, whole-person primary care, inclusive of integrated behavioral health.

Better Health—NOW supports the following legislation, introduced in the 118th Congress:

- **H.R. 7681, The Primary and Virtual Care Affordability Act**, which gives employers and health plan sponsors the flexibility to reduce or waive cost-sharing for primary care and extends the existing, waiver flexibility for telehealth services through 2026.
- **S. 655, The Chronic Disease Management Act**, which allows high-deductible health plans with HSAs to cover care for chronic conditions before exhausting the deductible.

Within the U.S. health care system, primary care is the level of care best positioned to beat back the endemic rates of chronic disease and spiraling costs. The need for bold Congressional action to champion primary care could not be more urgent.

We look forward to continuing to work with you to strengthen primary care. Please contact PCC's Director of Policy, Larry McNeely (lmcneely@thepcc.org) with any questions.

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The Society of General Internal Medicine (SGIM) thanks the Senate Finance Committee ("the Committee") for holding this hearing on how to better reimburse physicians and the care teams who deliver chronic care to Medicare beneficiaries and for providing this opportunity to submit this statement for the record.

SGIM is a member-based medical association of more than 3,300 of the world's leading academic general internal medicine physicians, who are dedicated to delivering high-quality clinical care, improving access for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to ensuring patients have equitable and affordable access to the highest quality of care possible.

Primary care is the foundation of a strong health care system. Primary care physicians, including general internal medicine physicians, provide a broad range of clinical services and expertise, from preventative healthcare to treatment of multiple chronic medical conditions. In addition, primary care physicians also serve as the coordinator of their patients' overall care. In this role, they not only coordinate with other physicians, nurses, pharmacists, and social workers within their practice but also specialists, mental health professionals, and laboratories outside of them. They ensure that other care team members understand the patient's medical history and comorbid conditions and that the decisions being made are patient-centered. Our members take pride in cultivating enduring, trust-based relationships with patients that span decades. However, despite the robust evidence that coordinated primary

¹⁰ Cohen, R.A., Zammitti, E.P. (2018). High-deductible Health Plan Enrollment Among Adults Aged 18–64 With Employment-based Insurance Coverage. 317. <https://www.cdc.gov/nchs/products/databriefs/db317.htm>.

¹¹ Cohen, R.A., Zammitti, E.P. (2018). High-deductible Health Plan Enrollment Among Adults Aged 18–64 With Employment-based Insurance Coverage. 317. <https://www.cdc.gov/nchs/products/databriefs/db317.htm>.

care improves health outcomes and equity, incentives and infrastructure are not in place to allow primary care to deliver on its promise.

This Committee must develop policies that will support the delivery of patient-centric care to Medicare beneficiaries and bolster the primary care workforce. The shortages of general internal medicine and other primary care physicians are well documented. The inadequate reimbursement for primary care generally and care coordination specifically has only perpetuated this shortage. SGIM members practice at the nation's medical schools and academic medical centers where they serve as educators and mentors. Therefore, we are ever mindful of the career choices made by students and residents and the influence compensation discrepancies between primary care and procedurally-oriented specialties have on those choices.

Without meaningful change, more patients—regardless of where they live—will experience challenges accessing comprehensive primary care. Primary care practices have been operating on minimal or even negative profit margins in recent years. The financial challenges as well as the long hours and administrative burden associated with the practice of primary care has brought the United States to the point that there is a severe shortage of general internal medicine and other primary care physicians. Without action, these shortages will only grow and become more problematic as the Medicare population ages and their needs for coordinated comprehensive care grow.

The overarching problems facing the Medicare Physician Fee Schedule (MPFS) are making it difficult to enact reforms to support primary care and chronic care delivery. As access to primary care services becomes more challenging, cognitive and procedural specialties are also being challenged by the downward pressure on Medicare physician payment, which has stagnated over the past 2 decades without receiving necessary increases or adjustments for inflation or to account for increased costs of providing comprehensive care in stark contrast to other Medicare fee schedules. According to an American Medical Association analysis of Medicare Trustees data, Medicare physician payment has declined by 30% percent when adjusted for inflation from 2001–2024.

Congress enacted the Medicare Access and CHIP Reauthorization Act (MACRA) to enable Medicare to pay for high-quality care rather than the volume of services provided. However, this experiment failed. MACRA only authorized 0.5% updates to the conversion factor through 2019. For the last several years, the lack of positive updates and the MPFS' budget neutrality requirements have resulted in cuts to Medicare reimbursement, which Congress has mitigated. While SGIM appreciates Congressional actions to minimize these cuts, the downward pressure on Medicare reimbursement continues and is exacerbated by the MPFS' budget neutrality requirements, which have not been updated since 1992. The budget neutrality threshold, which remains \$20 million, pits specialties against one another. As long as some specialties experience losses when new codes are added to the MPFS or positive updates are recommended for certain services, Congress and the Centers for Medicare & Medicaid Services (CMS) will not be able to transform the MPFS to support the delivery of high-quality coordinated primary and chronic care. Therefore, SGIM urges this Committee to make two structural reforms to the MPFS to support more equitable reimbursement: (1) an annual inflationary update to the conversion factor, and (2) an increase in the budget neutrality threshold to \$53 million from \$20 million with the provision of inflationary updates every 5 years thereafter. These two changes will help reverse the downward pressure on Medicare physician payment. Making all physicians' reimbursement more sustainable will allow the Committee to make additional changes to support the delivery of high quality primary and chronic care.

The significantly lower payment rates for primary care compared to those for procedural specialties discourage medical students from choosing primary care specialties, as they are attracted to higher-paying specialties particularly considering their growing amounts of medical school debt. As a result, many Americans do not have a primary care physician with whom they can schedule timely visits and receive longitudinal, comprehensive care; instead, they receive care from urgent care clinics and overcrowded emergency rooms. Even those with established primary care physicians have difficulty accessing the appropriate level of care, as primary care physicians are forced to see a higher volume of patients for shorter appointments. This leads to a viscous cycle of either less comprehensive care, or physicians being forced to work after-hours doing uncompensated but critical care coordination, leading to fatigue, burnout and erosion of the primary care workforce. Further, the persistent shortage of primary care physicians nationwide, particularly in rural communities,

exacerbates existing disparities among vulnerable populations that are already facing significant healthcare challenges.

CMS has taken steps in recent years to support primary care by creating new services, like those for chronic care management, and revising and revaluing evaluation and management (E/M) services. However, the lack of positive conversion factor increases and budget neutrality adjustments has eroded the value of these reimbursement increases for primary care. SGIM urges Congress to work with us to develop a set of reforms to support primary care and bring stability to the Medicare physician payment system. Specifically, Congress must improve reimbursement for the E/M services that are central to the comprehensive care of patients delivered by primary care physicians. Better reimbursement for these E/M services would also help to support the comprehensive care that many specialists deliver to patients with complex conditions such as diabetes mellitus, congestive heart failure, and kidney failure. Despite recent efforts to redefine and revalue E/M services, further improvements should be made to support patient-centered care, particularly for Medicare beneficiaries who have one or more chronic conditions.

SGIM believes that establishing a technical advisory committee (TAC) to define and value E/M and other non-procedural work is critical to appropriately reimbursing for primary care services and supporting the delivery of high-quality comprehensive care as outlined in Senator Sheldon Whitehouse's primary care discussion draft. This has been a longstanding priority of our professional society. SGIM believes that Congress should codify CMS' responsibility to ensure that the MPFS is accurate, reliable, and publicly accountable. A TAC could assess the existing processes for service code development and valuation and propose solutions that are sustainable and evidence based.

The TAC can begin making meaningful improvements to reimbursement for primary care now and ensure that the valuations of physician services provide reliable building blocks, which can be used in developing innovative alternative payment models like a hybrid payment system for primary care. Specifically, the TAC can determine how to base payments on the relative intensity of cognitive work by establishing a reliable process for defining services and assigning values. The existing mechanisms for valuing cognitive work are not evidence based and have helped perpetuate a system that has not prioritized primary care, while the volume and value of technical and procedural services has grown. SGIM believes that a TAC is critical to support primary care but recognizes that the existing mechanisms to value MPFS services may be better suited to be applied to procedures. This TAC does not have to replace the existing mechanisms for valuing all MPFS services.

As the population ages, Medicare must lead the way in supporting primary care and other cognitive based care (e.g., addiction treatment and behavioral health). A TAC will incorporate evidence-based data into the valuation process of E/M service codes and be best equipped to ensure that these services are evaluated at more regular intervals. We believe that a regular, independent assessment of available data and data-driven policy recommendations will stabilize what has evolved to become an irregular process, which has been a major contributor to the declining primary care workforce. Even as hybrid and other alternative payment models expand, the importance of proper valuation of E/M services and the critical role of a TAC will remain. Alternative payment models continue to be based on the underlying MPFS, and any payment model must have a strong primary care system as the foundation. Appropriate valuation of primary care will remain critical to ensure resources are appropriately distributed to enable high quality, comprehensive, patient-centered care.

Again, thank you for the opportunity to submit this statement for the record. SGIM looks forward to working with the Committee and the bipartisan working group on physician payment to meaningfully reform the MPFS.

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The Society of Gynecologic Oncology (SGO) applauds the Senate Finance Committee for holding the recent hearing, *Bolstering Chronic Care through Medicare Physician Payment*. This is an important step in protecting Medicare beneficiaries' access to high-quality care.

The SGO is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. Our more than 2,800 members include physicians, advanced practice providers, nurses and patient advocates who collaborate with the Foundation for Women's Cancer to increase public awareness of gynecologic cancers and improve the care of those diagnosed with gynecologic cancers. Our primary mission focuses on supporting research, disseminating knowledge, raising the standards of practice in the prevention and treatment of gynecologic malignancies, and collaborating with other organizations dedicated to gynecologic cancers and related fields, all with the ultimate vision of eradicating gynecologic cancers.

Gynecologic oncologists play a multifaceted role in providing care for women with gynecologic cancer. Gynecologic oncologists are involved in the diagnosis of gynecologic cancer, developing personalized treatment plans for patients, performing complex surgeries, overseeing the administration of chemotherapy, and monitoring patients to detect recurrence or complications. Unfortunately, Medicare reimbursement has not kept pace with the costs of delivering this complex care.

The entire physician community continues to face unpredictable Medicare reimbursement rates and rising inflation—a perfect storm of financial instability that threatens SGO members' ability to care for patients. Therefore, SGO recommends that Congress work with physicians to implement long-term, systemic reforms that bring stability to the Medicare physician payment system ending this cycle of annual payment reductions and preserving beneficiary access to medical services. Specifically, we urge you to consider supporting the following legislative solutions:

- *Annual Inflationary Adjustments:* The Medicare Physician Fee Schedule (MPFS) does not receive necessary increases or adjustments for inflation, in contrast to other Medicare fee schedules. Not only does the MPFS not receive annual inflationary increases, the last statutory increase to the MPFS conversion factor of 0.5% was applied in 2019. SGO supports an annual inflationary adjustment, equal to the Medicare Economic Index (MEI) or some other inflationary factor. An annual inflation-based update to the MPFS will help practices cover the growing cost of clinical staff, rent, medical supplies and equipment, malpractice insurance, and other necessary expenses. Moreover, it will help to protect the supply of our nation's physicians and preserve patient access to care, particularly in areas where there may be a shortage of specialized providers, like gynecologic oncologists.
- *Budget Neutrality:* Current Medicare statute requires changes to the MPFS be implemented in a budget neutral manner, which means that policies that increase or decrease Medicare spending by more than \$20 million require that upward or downward adjustments be made by that excess amount to all physician services. This threshold has not changed since 1992. SGO recommends that Congress consider raising the budget neutrality threshold from \$20 million to \$53 million to accommodate changes in Medicare spending, allowing for more flexibility in adjusting physician payments. Congress should also provide for an increase every 5 years equal to the cumulative increase in MEI to ensure that physician payments keep pace with inflation and the cost of delivering care.
- *Updates to Practice Expense:* Medicare bases its payment rates under the MPFS in part on estimates of the resources used in furnishing each service to a typical Medicare patient. For each service, there is a valuation for practice expense (PE), which is composed of the direct and indirect practice resources involved in furnishing medical services. SGO recommends that the Secretary of Health and Human Services, no less than every 5 years, update prices and rates for direct cost inputs for PE relative value units which includes clinical wage rates, prices of medical supplies, and prices of equipment. PE data should be updated on a regular basis to account for the inevitable changes in technology, practice patterns, clinical labor rates, and other factors that influence these inputs. Updating the data more regularly will provide greater stability within the payment system.

Moreover, SGO appreciates the Committee's interest in making improvements to the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP), including simplifying the Merit-based Incentive Payment System (MIPS) and identifying strategies to bolster widespread adoption of alternative payment models (APMs).

The purpose of value-based care programs is to drive down health care costs and improve patient outcomes, but those goals cannot be achieved without robust physi-

cian participation in these models. Unfortunately, there are challenges for physicians, such as financial risk and administrative burden. In an environment of stagnant Medicare reimbursement, physicians are even more averse to the financial risk posed by these programs. Additionally, physician practices vary by size, specialty, and location; therefore, it is important that APMs are developed in a way that is feasible and makes sense for different practices and patient populations. There are significant financial investments required to develop and implement an APM putting this option out of reach for many specialties or health systems. Congress should ensure that CMS is provided with the necessary resources to support measure and APM development allowing them to partner with interested stakeholders. It is critical that specialty physicians, like SGO members, are involved in designing APMs to ensure that alternative ways of delivering services are relevant to specialty practice, not overly burdensome, and support the needs of our patients.

SGO believes value-based care delivery is critical in maximizing quality and cost effectiveness. Therefore, we are pleased that CMS continues to develop and test new models suitable for a wide range of practices of different sizes and specialties. Today, specialty physicians, like gynecologic oncologists, will find few physician-focused models available to them. We recognize that CMS intends to sunset traditional MIPS and move to MIPS Value Pathways (MVPs), and the agency is continuing to roll out new pathways each year. However, specialties like gynecologic oncology do not yet have MVP options to participate. Besides simplifying the MIPS program, the SGO strongly believes that all providers should have measures and MVPs that reflect the patient care they provide. Therefore, we encourage CMS to work with stakeholders like SGO to support and incentivize the development of specialty and subspecialty specific measures to make participation more meaningful for providers, Medicare beneficiaries, and the agency.

The administrative requirements and reporting processes associated with CMS' quality programs can feel burdensome for providers. This comes at a time when providers are also experiencing burdensome prior authorization requirements in the Medicare Advantage (MA) program. Improving the program, which covers nearly half of all Medicare beneficiaries, is imperative to ensuring that seniors receive the highest quality of care. Prior authorization processes require practices to realign staff or hire additional staff for the sole purpose of doing this work. This comes at a time when there are staffing shortages throughout the health care system and funneling resources from direct patient care to prior authorization duties is not in the best use of limited resources, while taking away time and energy from direct patient care. Additionally, SGO members are concerned that this process leads to delays in patient care, which is particularly concerning when a patient has cancer and time is of the essence, leading to negative health outcomes. One study found that 25 percent of gynecologic oncology patients experienced prior authorization during their cancer care with patients experiencing over a 2-week delay in care when prior authorization occurred.¹ Reform is needed to reduce the burden of prior authorization in gynecologic oncology and SGO encourages you to review the prior authorization policies within the MA program to protect patient access to timely care.

Thank you for your leadership and interest in developing policy to stabilize the Medicare physician payment system to support providers and provide certainty for beneficiaries dependent on the program for their health care. We look forward to working with you to achieve these goals.

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UsAgainstAlzheimer's (UsA2) thanks the Finance Committee for holding this hearing on the vitally important topic "Bolstering Chronic Care through Medicare Physician Payment" and appreciates the opportunity to submit this Statement for the Record.

UsA2 was founded in 2010 to disrupt and diversify the movement to end Alzheimer's. Through urgent and inclusive mobilization, UsA2 has worked to dramatically increase funding for Alzheimer's and dementia research. Our work to stop Alz-

¹ Smith AJB, Mulugeta-Gordon L, Pena D, Kanter GP, Bekelman JE, Haggerty AE, Ko EM. Prior authorization in gynecologic oncology: An analysis of clinical impact. *Gynecol Oncol*. 2022 Dec;167(3):519–522. doi: 10.1016/j.ygyno.2022.10.002. Epub 2022 Oct 14. PMID: 36244827.

heimer's now centers on prevention, early detection and diagnosis, and access to treatments for all regardless of gender, race, or ethnicity.

Alzheimer's Is a Chronic Disease

Alzheimer's disease and related dementia (ADRD) is a chronic condition whose death toll is outpacing other chronic conditions such as heart disease, stroke, and cancer. ADRD is included on the Centers for Medicare & Medicaid Services' (CMS) list of chronic conditions identified in its advisory on chronic care management codes (MLN909188—Chronic Care Management,¹ page 6):

Alzheimer's disease and related dementia • Arthritis (osteoarthritis and rheumatoid) • Asthma • Atrial fibrillation • Autism spectrum disorders • Cancer • Cardiovascular disease • Chronic Obstructive Pulmonary Disease (COPD) • Depression • Diabetes • Hypertension • Infectious diseases like HIV and AIDS.

The Risk and Prevalence of ADRD Can Be Reduced

ADRD not only requires significant management, it is also interconnected to other chronic conditions and shares similar risk factors that if addressed could significantly reduce its prevalence by 40% or more.

Over the last decade, a growing and now undeniable body of evidence suggests that a significant percentage of dementia cases are, in fact, preventable or delayable, with the same strategies that can reduce the risk of other chronic diseases including cardiovascular disease, obesity, type 2 diabetes, chronic kidney disease, depression, and certain forms of cancer. These strategies include physical activity, proper nutrition, and sleep, and addressing other specific conditions that increase the risk of cognitive impairment including hypertension, hearing loss, and traumatic brain injury.

Because the science is now clear, the Department of Health and Human Services (HHS) in 2022 updated the National Alzheimer's Plan to Address Alzheimer's Disease to add a sixth goal: "Accelerate Action to Promote Healthy Aging and Reduce Risk Factors for Alzheimer's Disease and Related Dementias."

Achieving this goal means adopting strategies designed to combat chronic disease and promote a healthy aging agenda including interventions to encourage greater physical activity, a healthy diet, cognitive stimulation, hearing loss treatment, social engagement, and sleep hygiene. The evidence shows that the earlier people begin these activities the better opportunity they have to reduce their risk of ADRD. It is critical that Medicare reimbursement provides adequate payment for the services and supports provided by physicians to prevent and manage chronic conditions.

Even a 5-year delay in the onset of Alzheimer's disease would reduce the population with the disease by 41% in 2050, which could reduce annual costs by \$640 billion.² The Risk Reduction Subcommittee of the National Alzheimer Project Act Advisory Council set a goal of reducing dementia risk factors³ by 15% by 2030. A 15% proportional reduction in risk factor prevalence would be associated with approximately 427,000 fewer prevalent dementia cases⁴ in the U.S. population.

Early and Accurate Detection Is Essential

One of the most important policies the Finance Committee can advance in the area of prevention and risk reduction is early and accurate detection of Mild Cognitive Impairment (MCI), so patients and their medical team have as much time as possible to implement strategies to slow the progression of the disease.

The bicameral, bipartisan Concentrating on High-Value Alzheimer's Needs to Get to an End (CHANGE) Act (S. 2379/H.R. 4752) makes a point to strengthen dementia detection. The act directs CMS to require professionals providing the Medicare Annual Wellness Visit (AWV; 42 U.S.C. § 1395x [hhh]) and the Initial Preventive Physical Examination (also known as Welcome to Medicare Benefit, WMV; 42 U.S.C. § 1395x[ww][1]) to use cognitive impairment detection tools identified by the National Institute on Aging (NIA).

¹ <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf>.

² <https://www.degruyter.com/document/doi/10.1515/fhep-2014-0013/html>.

³ <https://aspe.hhs.gov/sites/default/files/documents/18454de4f0f9ef42dacef6ef167b1933/napa-2021-public-member-recommendations.pdf>.

⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9260480/#:~:text=A%2015%25%20proportional%20decrease%20in%20each%20risk%20factor%20would%20reduce,C1%2C%203.7%25%20D10.9%25>.

CMS currently encourages, but does not require, providers to use a brief validated structured cognitive assessment tool. Consequently, many providers use “direct observation,” rather than a validated tool, to assess patients’ cognitive health. Direct observation is the least useful and least appropriate tool, all too often contributing to under-diagnosis, delayed diagnosis, misdiagnosis, and non-disclosure of diagnosis. Recent studies showed that among patients aged 70 years or older, seen in primary care settings, cognitive impairment goes unrecognized in more than 50% of cases.⁵ Underutilization of validated assessment tools delays detection and diagnosis, resulting in decreased opportunities for people to implement important lifestyle modifications, access timely treatment options, and participate in clinical research. Use of these tools will allow clinicians to better detect MCI and other early symptoms of Alzheimer’s disease and related forms of dementia.

When people receive a timely and accurate diagnosis, they have improved opportunities to make informed and productive lifestyle, medical, financial, legal, and spiritual choices to strengthen both their own quality of life and that of their family caregivers. The CHANGE Act would help providers detect Alzheimer’s sooner, which is increasingly important in light of new Food and Drug Administration (FDA)-approved and Medicare-covered therapies for use in early-stage Alzheimer’s disease. It is also critically timed, as Medicare prepares to launch its nationwide comprehensive dementia care model.

CMS could adopt this this pragmatic policy administratively, and the bill sponsors have long encouraged CMS to act. We are aware of CMS concerns about overburdening primary care doctors. In response, the bill sponsors significantly narrowed the bill, clarifying that clinicians can use any one of the NIA-identified tools, including brief assessments.⁶ Three of these tools can be filled out by the patient and caregivers before the visit, which means doctors would not bear added burdens. This small change puts patients concerns first.

We urge the Committee to include the CHANGE Act in any package of policies designed to advance “Bolstering Chronic Care through Medicare Physician Payment.”

In conclusion, as the Committee considers policies designed to “Bolster Chronic Care,” ADRD should be included on the list of conditions it considers, alongside cardiovascular disease, type 2 diabetes, hypertension, and other conditions that have more traditionally been seen as chronic conditions. For too long, Alzheimer’s and Related Dementia has gone unaddressed, and we know now there is much we can do to reduce the risk, detect it early, manage the disease, and soon (we hope) effectively cure it.



⁵ <https://www.nia.nih.gov/health/health-care-professionals-information/assessing-cognitive-impairment-older-patients>.

⁶ <https://alz-journals.onlinelibrary.wiley.com/doi/full/10.1002/alz.13051>.